



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Health Insurance for Unemployed Workers

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for

“Economic Security: Helping Working Americans and Those Out of Work”
Committee on Health, Education, Labor, and Pensions
United States Senate

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Thank you for the opportunity to offer testimony at this hearing on “Economic Security: Helping Working Americans and Those Out of Work.” I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. The national, bi-partisan Commission serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform.

Today, millions of America’s workers and their families are at risk of losing not only their jobs and family income, but also their health insurance coverage. Health insurance is essential to assuring access to health care and providing financial security from medical bills, debt, and even bankruptcy. My testimony today will assess the impact of the economic downturn on health coverage for America’s workers and review the approaches available to secure coverage for unemployed workers and their families.

HEALTH INSURANCE COVERAGE OF WORKERS

Today, health insurance and employment are intricately linked. Most working Americans and their families have employer-based coverage: nearly two-thirds of all Americans have employer-sponsored health insurance. Employer-sponsored health insurance has developed and thrived for a variety of reasons, including preferential tax treatment, the ability to pool employees together to balance risk, and the advantages of group purchasing power.

The employment setting has enabled millions of Americans to sign up for health insurance with minimal administrative burden to the worker, as the employer typically absorbs that task. Employees obtaining health insurance through their employer have the additional advantage of more affordable premiums than are otherwise available, since the employer typically shares in the cost of coverage. In 2001, employers paid

approximately 75 to 86 percent of the average premium for employer-sponsored coverage, about \$221 per month for an individual and \$588 for a family (Figure 1).

While the employer-based system of health insurance has provided affordable coverage to millions of Americans, coverage is limited. Not all workers have access to coverage because some employers do not offer coverage or limit coverage to full-time workers. Firm size, industry and occupation, and wage are key factors that affect the likelihood that a person is offered employer-sponsored coverage. Low-income workers are the most disadvantaged with respect to employer-sponsored coverage. Only 38 percent of low-income workers (those with incomes below 200% of poverty) have coverage through their employer compared to 87 percent of workers with incomes above 300 percent of poverty (Figure 2).

Although most working Americans have employer-sponsored health insurance coverage, a significant share (17%) of workers remain uninsured. In 1999, when the economy was strong, over 40 percent of workers with incomes below 200 percent of poverty were uninsured, compared to just seven percent of workers with incomes above 300 percent of poverty. Uninsured workers often delay or skip needed treatment and incur substantial financial burdens as they try to meet their families' medical needs.

Without Medicaid coverage, millions more low-income workers and their children would be uninsured. Medicaid, supplemented in 1997 by the State Children's Health Insurance Program (CHIP), fills in the gaps in employer coverage. Today, 21 million children and 8.6 million non-elderly adults rely on Medicaid for their health insurance; another three million children obtain coverage through CHIP.

Expanded coverage of children and welfare reform have severed Medicaid's welfare roots and dramatically changed its focus to a health insurance program for low-income people. Two-thirds of non-elderly Medicaid enrollees come from working families; less than a quarter of enrollees receive welfare assistance today (Figure 3).

THE IMPACT OF A RECESSION ON EMPLOYER-SPONSORED COVERAGE

In recent years, the thriving economy helped to moderate growth of the uninsured population as employers used health care benefits as a way to attract and retain workers in a competitive market and Medicaid and CHIP expanded available coverage for children. The economic downturn now places health insurance coverage for working families in jeopardy from both loss of employer-sponsored coverage and limits on the availability and scope of Medicaid as a fallback. Both employer-sponsored coverage and Medicaid—and, as a result, the number of uninsured—are sensitive to economic conditions. In times of recession, employer-sponsored coverage declines, and while Medicaid absorbs some of the loss in coverage, many more people go uninsured. Forecasts by the Employee Benefits Research Institute predict that a severe economic downturn could add another 20 million people to America's 40 million uninsured over the next decade.

For people with coverage through their employer, an economic downturn poses the obvious threat of loss of their jobs and, with job loss, loss of their health insurance coverage. In addition, the changing economy also poses other threats to coverage for workers. Employers who began to offer coverage to lure workers in a tight labor market are likely to cut back on those offers. Employees' hours may be cut back, making them ineligible for health benefits as part-time workers. As employers face shrinking profits, they may also look to health insurance as a way to cut costs, either by cutting eligibility for some workers, cutting back benefits, or passing a larger share of the cost of insurance on to employees.

All of these scenarios are made even more likely by the fact that the cost of employer-sponsored coverage is rising again after several years of decline. According

to our recent survey of employer-sponsored health benefits, premium costs increased on average 11 percent in 2001. However, even more troubling, most employers, especially large employers who are most likely to offer coverage, reported it was likely that these increased costs would be passed along to their employees by increasing their premium share or reducing plan benefits. For workers with marginal incomes, such actions could make maintaining coverage for themselves and their families unaffordable.

THE IMPACT OF A RECESSION ON MEDICAID

While State Medicaid programs serve as a safety net alternative and fallback for some people without the option of employer coverage, Medicaid programs are not isolated from the problems of an economic downturn. Medicaid programs get caught in the crossfire during difficult economic times between the need for increased coverage and spending and the erosion of state revenues and constraints on state budgets. Medicaid is designed to be counter-cyclical: as unemployment rises and incomes drop, more people become eligible for Medicaid, which should result in more Medicaid spending and an infusion of more dollars into the economy. Using Congressional Budget Office estimates of Medicaid enrollment in 2002, simulations by the Urban Institute predict Medicaid enrollment for children and non-elderly adults at 40.3 million when unemployment is at 4.5%, but rising to 43.5 million if unemployment rises to 6.5%, assuming no other changes than those directly attributable to increases in unemployment (Figure 4). Such increases in Medicaid enrollment have fiscal implications for federal and state Medicaid spending.

On average, the federal government pays 57 percent of Medicaid spending for all people who are eligible, ranging from 50 percent in 11 states to over 70 percent in the 10 poorest states and the District of Columbia (Figure 5). Open-ended federal matching funds through Medicaid allow spending to increase automatically in response to higher

enrollment levels, but states must provide matching funds to avail themselves of the federal assistance. As a result, state spending for Medicaid represents a large share (on average, 15%) of most state budgets (Figure 6).

Reduced state revenues are placing severe strains on many state budgets and could limit expanded coverage at the time when additional coverage and spending is most needed. After strong economic growth during the mid- to late-1990s that allowed states to build up significant balances, at the end of 2000 states began to see their tax collections fall and their spending exceed expectations. As a result, many states had to dip deeply into their year-end balances to cope with budget pressures. According to the National Association of State Budget Officers, by August 2001, more than half the states were either in recession or near recession.

A review of state spending projections, prior to September 11, revealed relatively low growth projections for overall state budgets (2.4%) but substantially higher projections for Medicaid (8.9%), leaving limited room for growth in other state programs and putting renewed fiscal pressure on Medicaid (Figure 7). Since the terrorist attacks of September 11, the rate at which states' fiscal conditions are deteriorating is accelerating, and many states have either made budget cuts or announced plans to do so. In many cases, states are looking to cut Medicaid as part of their efforts to address budget shortfalls. The situation is exacerbated by rising Medicaid costs precipitated by rising prescription drug costs. If states respond to their difficult fiscal situations by cutting Medicaid in the months ahead, it will not only make it more difficult for newly unemployed workers to secure coverage, but also could reduce coverage for those currently enrolled. This action would in turn deepen the negative effects of the economic downturn.

COVERAGE OPTIONS FOR UNEMPLOYED WORKERS

Nothing is simple in the American health care system, and the interaction between health insurance and job loss is equally complex. What happens to an unemployed worker depends first, and foremost, on whether that worker had employer sponsored coverage prior to the job loss and whether the worker is eligible to extend that coverage under what is known as the COBRA option. An unemployed worker can extend coverage through COBRA, if eligible; purchase insurance directly in the individual market; transfer coverage to a spouse's employer-based policy, if available; or seek coverage through Medicaid. Those with low-incomes are less likely to have health insurance when employed and the fewest options when laid-off; many low-income adults are not eligible for Medicaid. Unfortunately for many, becoming or remaining uninsured may be the most realistic option.

Utilizing the COBRA Option

In 1985, Congress adopted the Consolidated Omnibus Budget Reconciliation Act, referred to as COBRA, to help unemployed workers and their families stay insured even after they lose their jobs. COBRA provides an important option to allow individuals and their families to retain their employer-sponsored coverage during job transitions. However, to utilize this option, the workers must have health insurance while employed; COBRA provides a bridge to maintain coverage between jobs, but it does not offer any new coverage.

For active workers, COBRA requires group health plans, including self-insured plans, to offer qualified part-time and full-time employees, as well as their spouses and dependents, the opportunity to buy into these plans under certain conditions. Individuals qualify for COBRA if they work for a firm with 20 or more employees and their job is terminated or their hours of work are reduced for reasons other than gross misconduct.

The COBRA option allows qualified individuals to purchase coverage under the employer's group health plan at full cost (including both the employer and the employee's share of the premium) plus two percent of the premium to cover administrative expenses. To take up the COBRA option, the worker, and his or her spouse and dependents if they desire coverage, must have been covered by the employer plan when the worker was employed. Under COBRA rules, workers do not have to be unemployed in order to qualify for the COBRA option; some workers take up the COBRA option and continue the option even after they find a new job.

The COBRA option is time limited. Coverage is generally available for a period of 18 months. If the qualifying individual is or becomes disabled, an additional 11 months of coverage can be purchased for 150 percent of the cost of the premium. Premiums are paid monthly, with the first payment due within 45 days of electing COBRA. Third parties, such as a state Medicaid agency, the worker's union, or a new employer, can make payments on a worker's behalf. Benefits remain identical to those provided to employed individuals currently covered by the employer group plan.

COBRA has been an important bridge providing health coverage between jobs for eligible workers. Roughly 4.7 million people – one in five of those eligible for COBRA – used COBRA coverage in 1999. This number includes both employees and their spouses and dependents.

While COBRA has been literally a lifesaver for many people, the COBRA option is unlikely to be a cure-all for workers losing health insurance. The federally-established COBRA option does not apply to individuals and families of individuals who work for firms employing fewer than 20 workers. In 1999, nearly 39 million workers were employed in firms with fewer than 25 workers. While 38 states have enacted legislation to provide COBRA-like options to some employees, these provisions mostly apply to

some small firms for a limited period of time (but often less than the 18-month federal guarantee). Self-employed workers also fall outside COBRA's protection.

One of the biggest impediments to COBRA's impact is the fact that access to the option is further limited to the insured working population. COBRA is only available to individuals who were covered under the employer plan the day before the worker lost his or her job. Workers and their spouses and dependents who were either not offered job-based coverage or were offered coverage but could not afford to take up the offer do not qualify for COBRA. Because of these limits on eligibility, only 57 percent of workers and their adult dependents are eligible for COBRA (Figure 8). Without employment income, health insurance choices and affordability are further compounded for workers who lose their jobs.

Certain workers are disproportionately affected by COBRA eligibility limits. Only one third (32%) of low-income workers and their adult dependents qualify for COBRA coverage, compared to two-thirds (67%) of high-income workers. These differences exist because low-wage workers are much less likely than higher-wage workers to be employed in settings that offer coverage. Over half of workers earning less than \$7 per hour are not offered coverage through the workplace or are ineligible for the coverage because they are employed part-time or have been recently hired. In contrast, only 9 percent of workers earning at least \$15 per hour are not offered workplace-sponsored coverage (Figure 9). When coverage is available, many low-wage workers find the employee premium share and cost-sharing expenditures beyond their seriously limited budgets. As a result, low-wage workers are more likely to be without employer-sponsored coverage than higher income workers and their families. Even with the robust economy in recent years, low-wage workers have continued to lag considerably behind the higher wage workforce in terms of employer-sponsored coverage.

Lack of employer-sponsored coverage is especially a problem for people who work in small firms —most notably, low-wage, small firms (Figure 10). Only 65 percent of firms with fewer than 200 workers offer coverage today, versus 99 percent of larger firms. People employed in retail and agricultural settings and those in less skilled positions are also less likely to be offered employer-sponsored coverage than workers in government and manufacturing firms. Food service workers, hotel aides, and others in the service, tourism, and retail industries are particularly at risk of working in settings that do not offer health coverage as an employer benefit (Figure 11). Less than half of agricultural and food service workers have employer-sponsored health coverage, compared to 84 percent of managerial and professional workers.

For those who are eligible, the cost of COBRA coverage can be an overwhelming barrier. It is difficult for individuals and families to pay the full cost of premiums, picking up the employer share of the premium, plus the two percent administrative fee at a time when their income has been cut drastically. A family receiving the average monthly unemployment benefit of \$925 per month with no other income would need to spend nearly two-thirds (65%) of the family's monthly income to maintain family coverage at \$600 per month under the average cost COBRA option (Figure 12). This average masks significant variations in health insurance premium costs and unemployment insurance levels by state.

The cost and eligibility limitations result in only 7 percent of unemployed adults electing COBRA coverage (Figure 13). Those with higher incomes and those with significant health care needs are more likely to take up the COBRA option. Among unemployed adults, 11 percent with high incomes (above 300% of poverty) utilize the COBRA option compared to 9 percent of those with moderate incomes and 5 percent of those with low incomes (below 200% poverty). For people with both low and moderate

incomes, over half of unemployed adults who do not have COBRA coverage go uninsured.

Many who elect the COBRA option have health problems or family members with health problems. For them, maintaining coverage under COBRA despite the high cost is preferable to seeking coverage in the individual market, where the costs are equally high, but prior health conditions are often excluded. As a result of this adverse selection, the average health care costs of those electing COBRA coverage is about 50 percent higher than the cost of covered employees.

If COBRA is to be a viable option to continue health coverage for the unemployed workers and dependents who qualify for this coverage, an adequate subsidy needs to be available to make COBRA coverage affordable during the period when the worker has lost employment income. The experience of one state (Massachusetts) showed that even with a 40 percent subsidy of COBRA coverage, few take up the option due to the remaining high cost of coverage. A 75 percent subsidy of COBRA would approximate the average share now covered by most employers, but could still be a struggle for many workers because of their diminished income while unemployed. While most families relying solely on unemployment insurance benefits are not likely to be able to afford the COBRA option without a full subsidy, a substantial subsidy is likely to improve the COBRA take up rate, especially for families with a source of income in addition to unemployment benefits.

Utilizing Medicaid as a Safety Net

The affordability and eligibility issues of COBRA and the limitations of the individual market leave millions of workers and their families at risk of being both unemployed and uninsured. For these families, publicly sponsored coverage through

Medicaid and coverage for children through CHIP is an effective and efficient means to fill in the gap.

Medicaid is a broad program providing health and long-term care coverage to one out of ten Americans, including seven million low-income people with severe disabilities. It provides a safety net for some workers who lose their jobs and have no health insurance coverage, including those who are not eligible for COBRA or cannot afford the COBRA option. In addition, Medicaid can complement the COBRA option by picking up the unsubsidized cost of COBRA coverage for low-income workers.

Coverage expansions beginning in the early 1990s focused on broadening coverage for poor children and pregnant women. Coupled with the implementation of CHIP in 1997 to supplement Medicaid and extend coverage to more low-income children, these expansions have provided substantial protections for low-income children. Currently, 38 states cover children with incomes at least up to 200 percent of the federal poverty line, and, as a result, ninety-four percent of all low-income uninsured children are eligible for either Medicaid or a separate CHIP program (Figure 14).

However, coverage for parents is not nearly as broad as the coverage available for their children, and assistance for childless low-income non-disabled adults remains outside the scope of Medicaid in most states. Parents can qualify for Medicaid (that is, are included within a Medicaid eligibility category) if their income falls below the income eligibility levels that are set by the states subject to federal minimum requirements. These income standards are quite low in most states and considerably below the current levels for children (Figure 15). In 34 states, parents are ineligible for Medicaid if their income exceeds the poverty level, and in 28 states, parents are not eligible if their income is more than half the poverty line (Figure 16). However, in recent years, several states, including Connecticut, New York, Rhode Island, Maine, Vermont, Minnesota,

Missouri and Ohio, have expanded coverage for parents through Medicaid. Others were poised to take similar steps before the slowdown in the economy.

Workers without children are the least protected of all individuals who might lose their jobs and need health insurance coverage. In general, the Medicaid program does not cover childless individuals unless they are elderly, disabled, or pregnant—no matter how low their income. A handful of states have Medicaid waivers to cover these individuals, but by and large they have been left out of publicly funded program coverage.

As a result, Medicaid (and CHIP) today offers the potential to provide coverage to most children in families with income below 200 percent of poverty, but offers only limited assistance for low-income adults (Figure 17). Among the low-income uninsured adults, over two-thirds of the 5.4 million parents and 90 percent of the 13.6 million childless individuals remain outside Medicaid's reach. The economic downturn and loss of jobs will only serve to increase these numbers.

Given the different patterns of eligibility and coverage under Medicaid and CHIP for different groups of individuals who are likely to be affected by the downturn in the economy, different measures may be needed to bolster coverage among low-income individuals and families who are adversely affected by the economic downturn. Bringing the income standards for parents up to eligibility levels for children would help to unite family coverage and provide greater health security for low-wage working families where jobs are at risk. For low-wage individuals without children, federal assistance for Medicaid coverage is not available because of the categorical restrictions on use of federal matching funds. Either opening eligibility to all individuals on the basis of income or creating a new category of coverage for displaced workers would provide access to coverage for low-wage workers.

However, simply opening the option to provide broader coverage through Medicaid will do little to ease the problem if the revenues are not there to support states in utilizing these options. Indeed, as noted earlier, many states may actually be in the position of cutting their Medicaid spending in the months ahead, rather than expanding their programs. The economic downturn both swells the ranks of the uninsured and depletes state coffers.

Initiatives to assist unemployed workers by extending public coverage will undoubtedly require the infusion of additional federal and state revenue. The current open-ended entitlement financing of Medicaid provides for additional dollars as enrollment grows and is not capped. CHIP funds, on the other hand, are capped, and each state receives an annual federal allotment that is matched by state funds.

Although there is currently an estimated \$11 billion in “unspent” CHIP funds, most of these funds are necessary to cover children over the next several years. Reprogramming these dollars for the unemployed could stymie state progress in insuring more low-income children. The statutory dip in federal CHIP funding between fiscal year 2002 and 2005 will cause a tightening of limited CHIP resources, prompting the Office of Management and Budget to project a decline in the number of children covered in 2005 (Figure 18). Moreover, the degree to which CHIP allocations are not fully spent varies widely across states. With the economy declining, diversion of CHIP funds could compromise efforts to reduce the number of uninsured children.

CONCLUSION

Given the recent economic downturn, it appears we are facing a difficult time with the potential of seeing health care coverage erode for millions of Americans. Health care is a central component of our nation’s economy, and erosion of coverage could prompt cutbacks in the health industry, which would in turn further accelerate the

downturn. Thus, maintaining coverage as we face this economic downturn is important not only for workers and their families, but also for reviving our ailing economy.

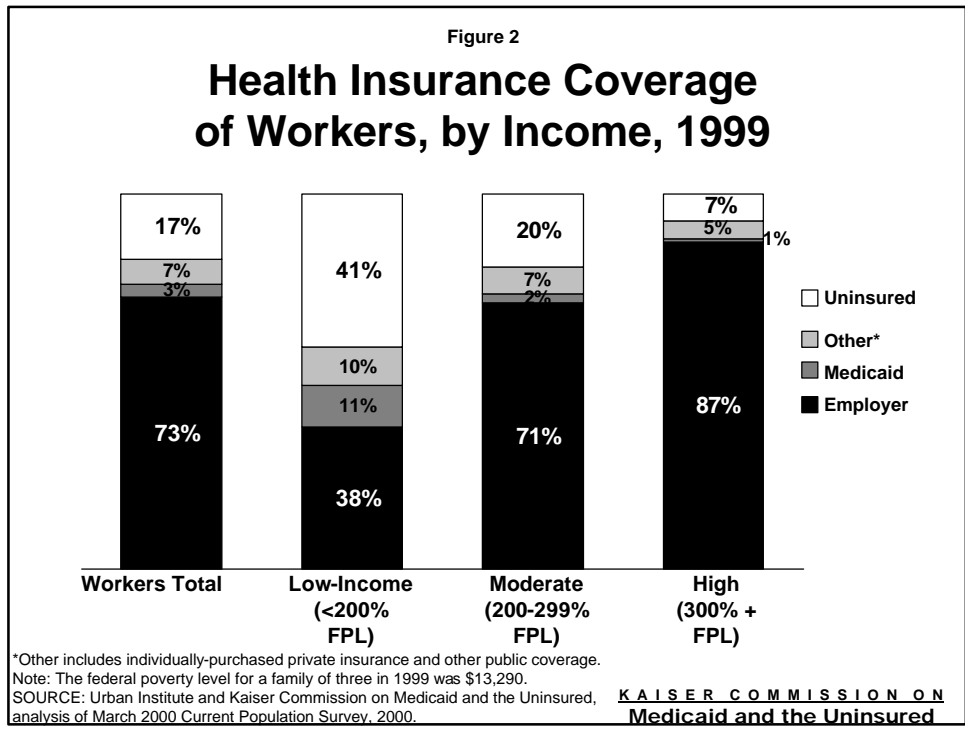
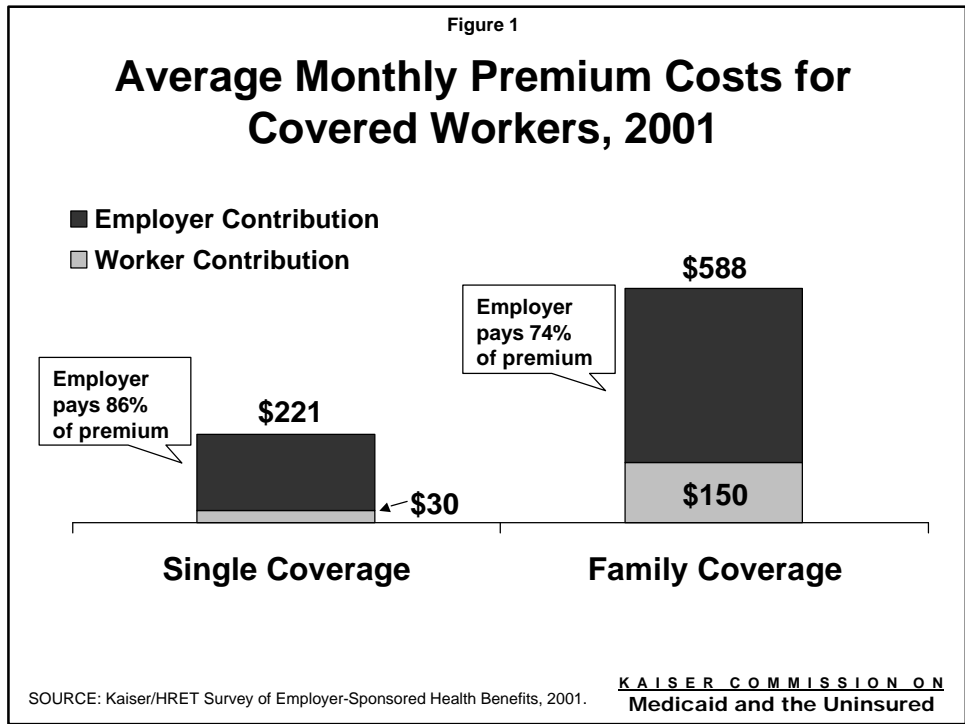
Helping laid-off employees to maintain their employer-based coverage is an important, but limited, first step. COBRA provides an option for some people currently covered through their employer, but it is expensive. To make COBRA an effective option for those who are eligible for it requires subsidizing a substantial share of the cost so that unemployed workers will be able to afford coverage within their limited resources. Regardless of the size of the subsidy, a large share of the uninsured workers will not be able to take advantage of a COBRA option because they are simply not eligible for it.

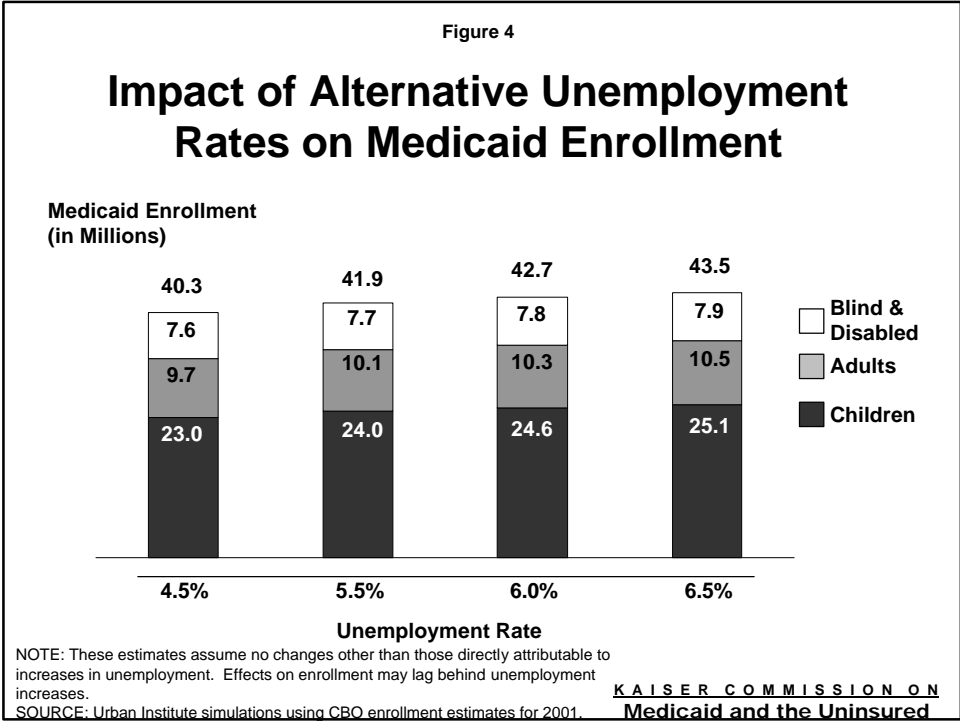
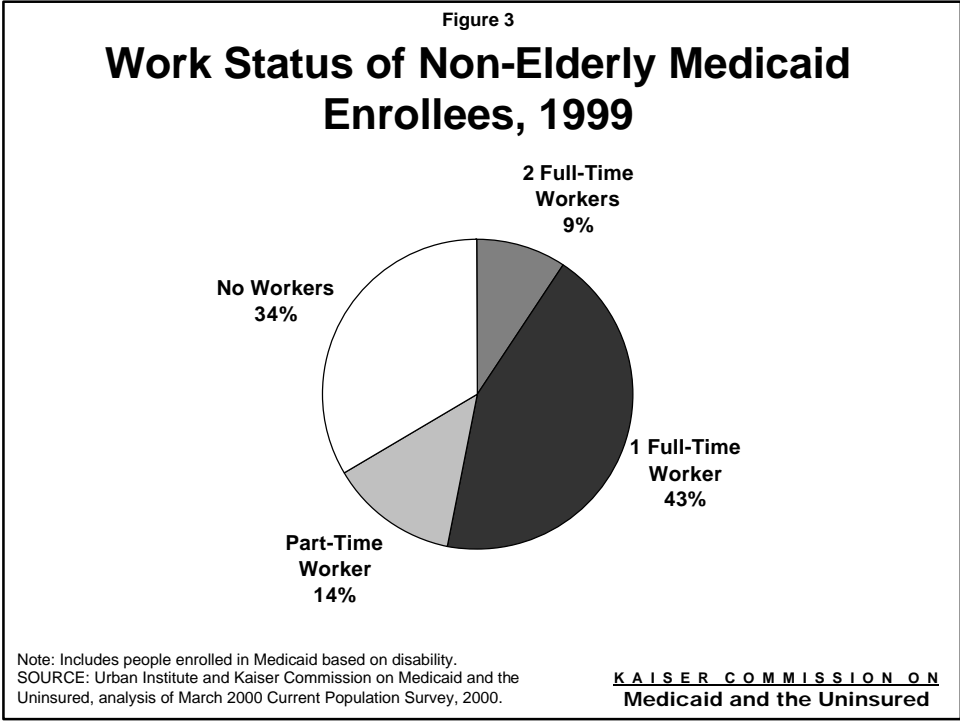
For most unemployed workers, especially those in the low-wage occupations that are likely to feel the most immediate impact of an economic downturn, Medicaid is likely to be the most efficient and effective option. It is a program already in place and capable of expanding to meet increased need quickly. States have regularly turned to Medicaid to expand coverage to their residents, and the federal financing grows with increases in enrollment and spending. The dollars follow people through the matching rate, avoiding the need to determine how to allocate dollars or set appropriate levels to respond to need. There are no equity issues for states, as each state gets matching funds according to what it spends.

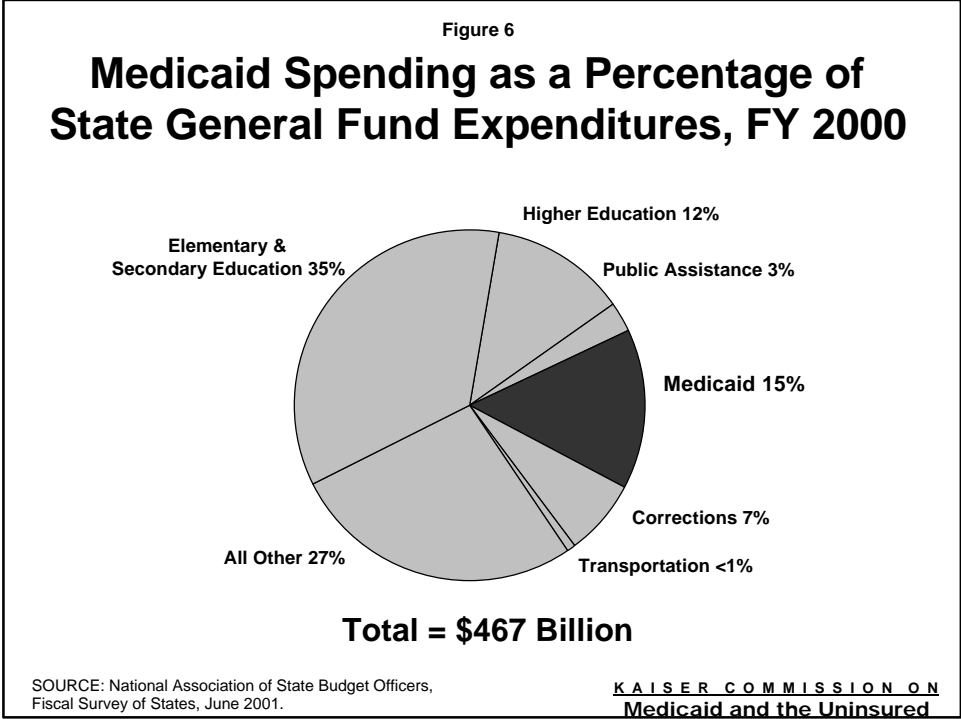
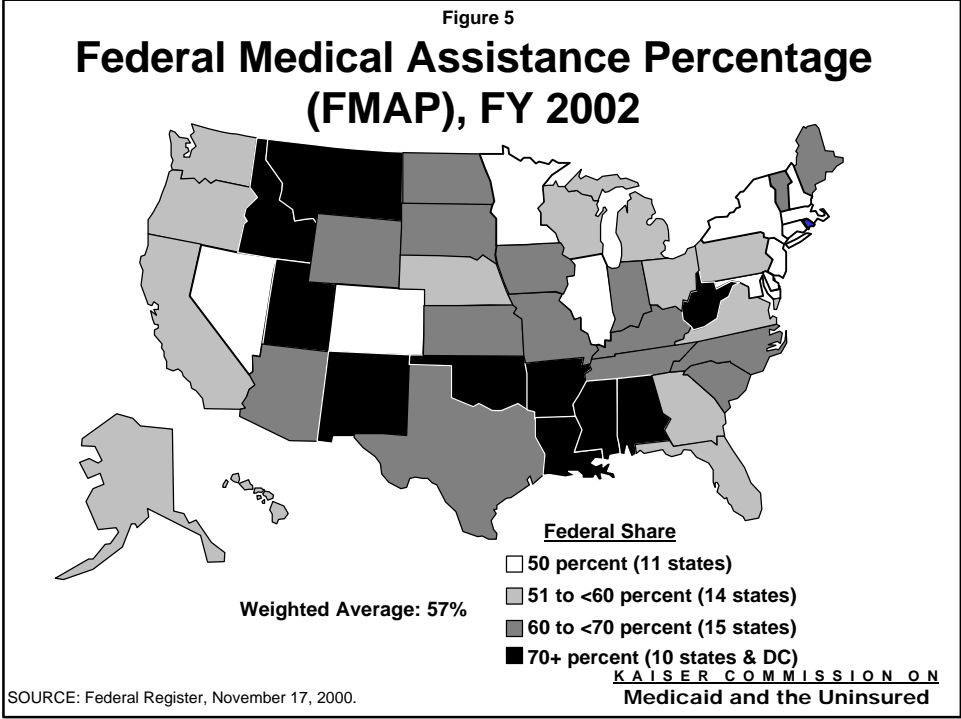
With additional resources and flexibility to extend coverage to low-income parents and other adults suffering a job loss, Medicaid can quickly respond to the health care needs of the most vulnerable among the newly unemployed. In these tight budgetary times, recognition must also be given to limits on states' ability to finance additional coverage and sustain the health and long-term coverage Medicaid now provides to over 40 million low-income Americans. Financing coverage for unemployed workers through COBRA and Medicaid and helping state Medicaid programs to be able to absorb additional enrollees and maintain coverage will be costly, but America can ill

afford to add millions of working families to the uninsured population. Helping to secure health insurance for unemployed workers and their families is an investment in America's workforce and a critical component of any economic stimulus package.

Thank you for this opportunity to testify before the committee. I would be pleased to answer any questions.







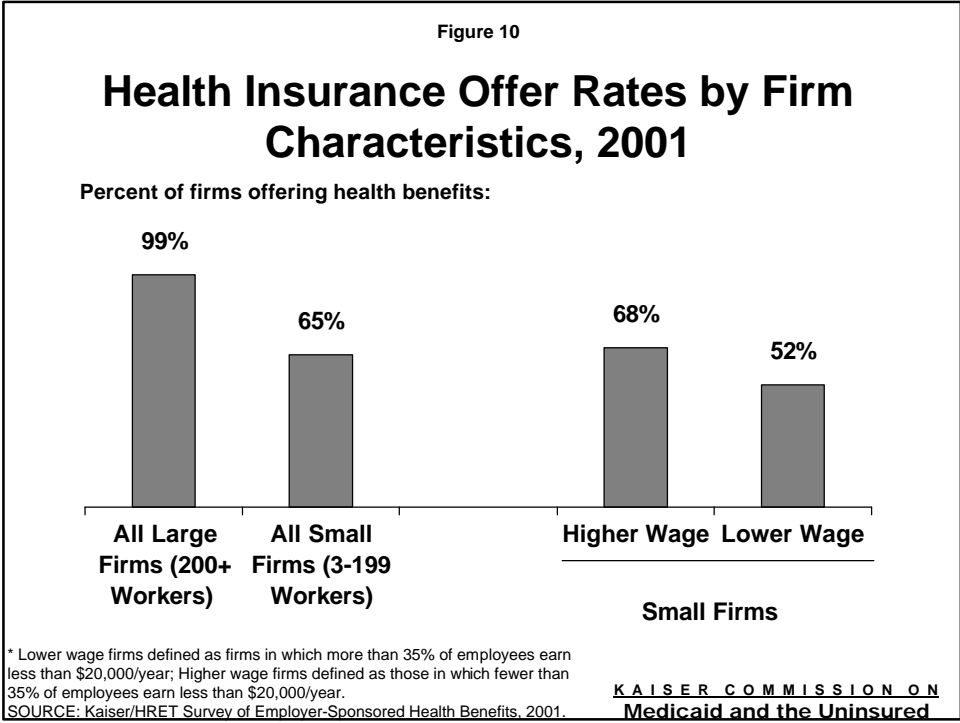
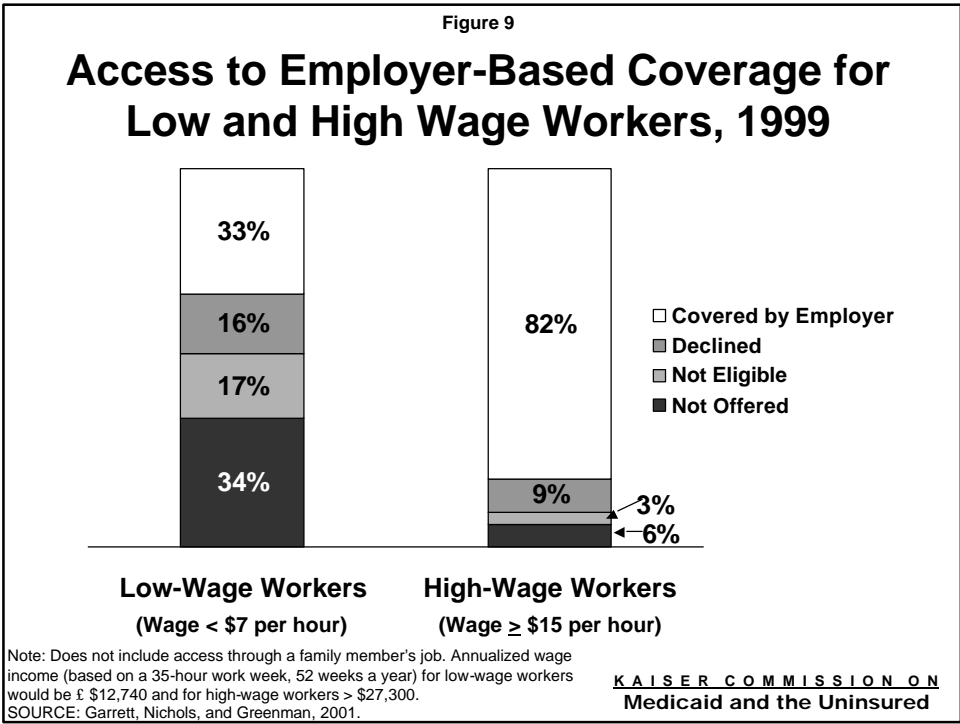
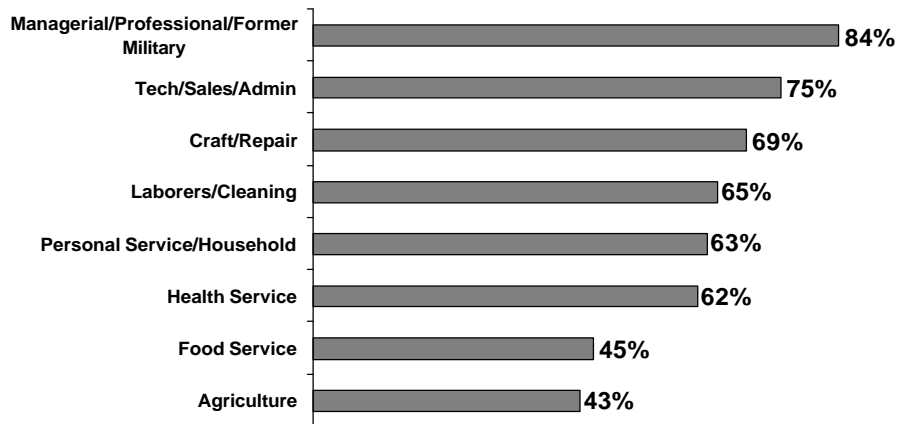


Figure 11

Percentage of Workers with Employer-Sponsored Health Coverage, by Occupation, 1999

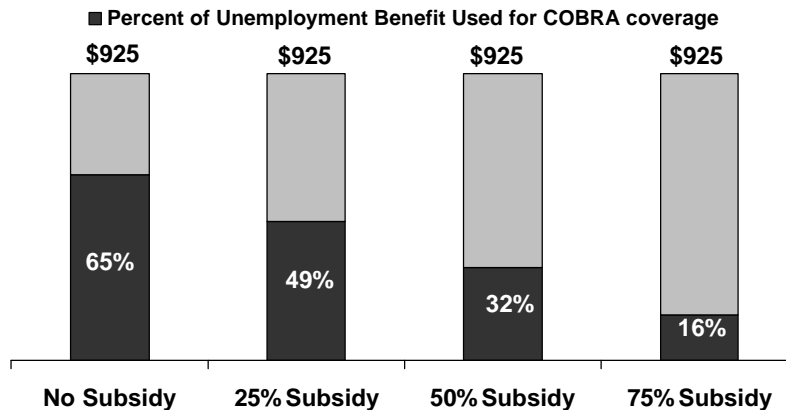


SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2000 Current Population Survey, 2000.

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Figure 12

Cost of COBRA Coverage as a Share of Unemployment Benefits



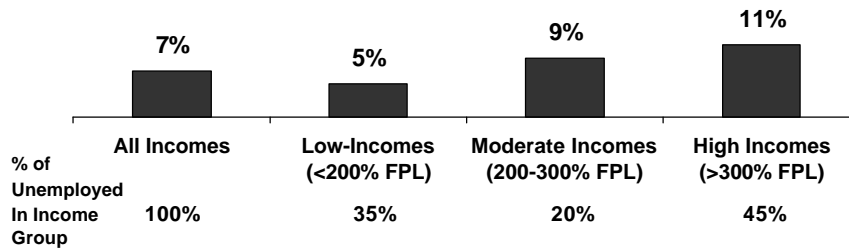
SOURCE: Average unemployment benefit from U.S. Department of Labor, January 2001; average cost of COBRA coverage based on 102% of average cost of family coverage for employer-sponsored insurance, from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001.

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Figure 13

COBRA Participation Among Unemployed Adults, by Income, 1999

Percent with COBRA coverage:

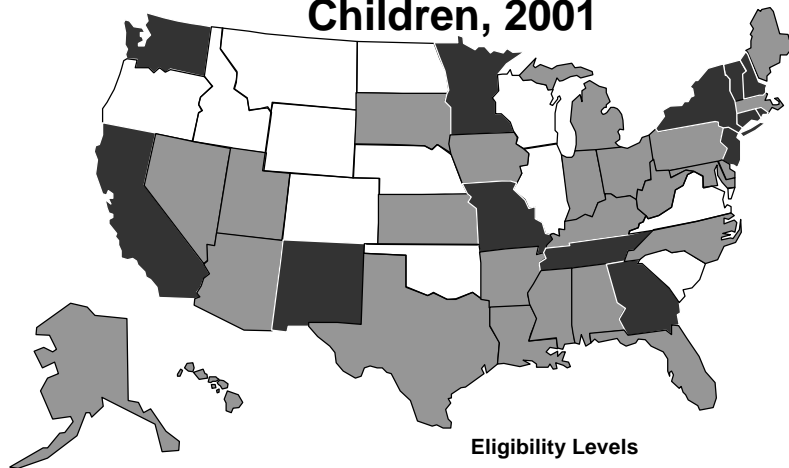


SOURCE: Zuckerman, Haley, and Fragale, 2001.

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Figure 14

Medicaid/CHIP Income Eligibility Levels for Children, 2001



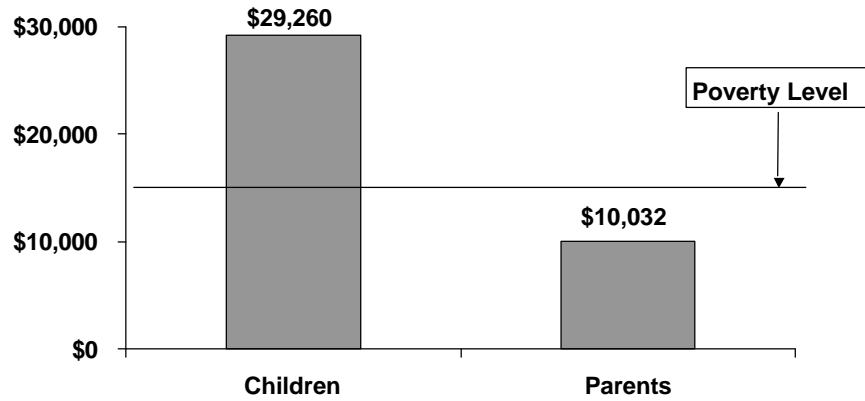
Note: The Federal Poverty Level (FPL) is \$14,630 for a family of three in 2001.
SOURCE: Center on Budget and Policy Priorities, January 2001.

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Figure 15

Differences in Income Eligibility for Parents and Children

Median earnings eligibility threshold for a family of three

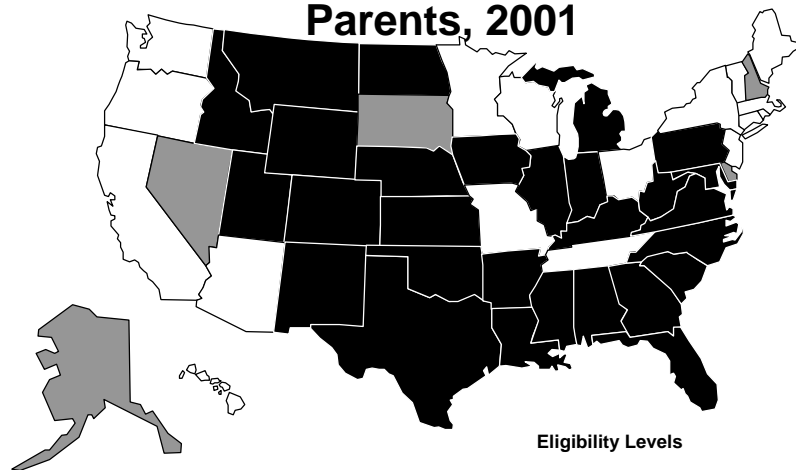


SOURCE: Center on Budget and Policy Priorities, 2001.

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Figure 16

Medicaid/CHIP Income Eligibility Levels for Parents, 2001

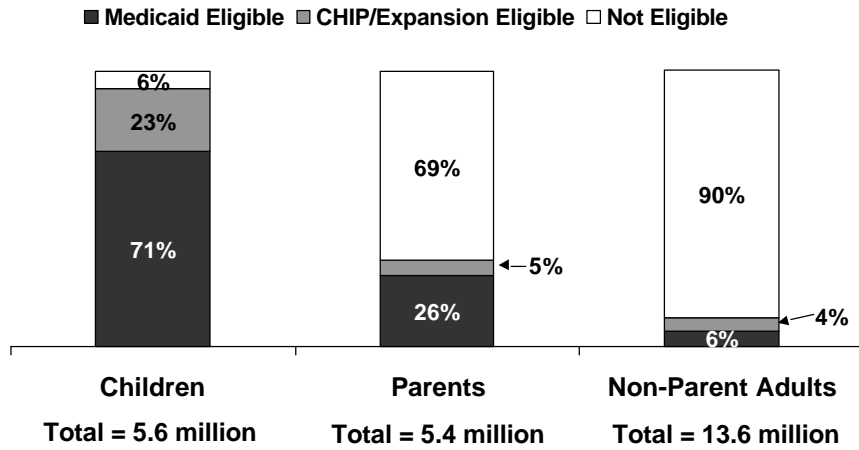


* Indiana has enacted but have not yet implemented their expansion for parents. In Tennessee, enrollment is currently closed to adults. The federal poverty level is \$14,630 for a family of three in 2001. SOURCE: Center on Budget and Policy Priorities, 2001.

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Figure 17

Eligibility for Public Programs Among the Low-Income Uninsured

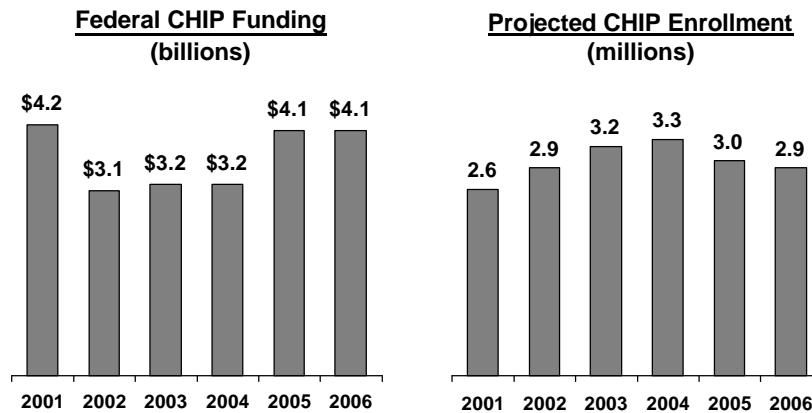


NOTE: Low-income refers to families with incomes less than 200% of the Federal Poverty Level.
 SOURCE: Urban Institute simulations, 2001. Based on the March 1997 Current Population Survey, projected to 1998, using 2001 eligibility rules.

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Figure 18

State Children's Health Insurance Program (CHIP) Funding and Enrollment, 2001-2006



NOTE: Enrollment projections for 2001 based on full-year equivalent enrollment.
 SOURCE: OMB, January and April 2001.

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