

medicaid

and the uninsured

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Health Coverage for the Unemployed

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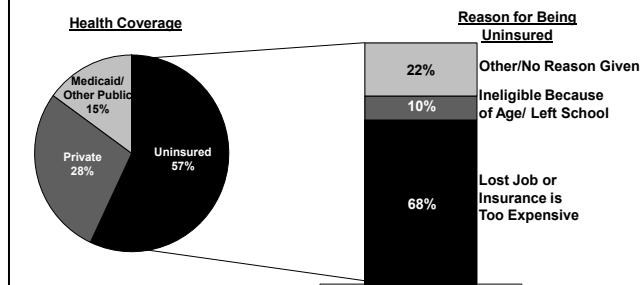
In May 2011, 13.9 million people in the U.S. were unemployed, and 6.2 million of these workers had been unemployed for six months or more.¹ The weak job market jeopardizes health coverage for the 57% of the nonelderly population in the U.S. that receive health insurance through an employer.² When individuals with employer-sponsored coverage become unemployed, they face the loss of both income and health insurance. Moreover, any of the employee's dependents that are covered through the employer could also lose coverage. The long-term unemployed are particularly vulnerable to loss of coverage as they face extended periods of reduced or no income.

In 2009, more than half (57%) of adults who were unemployed and looking for work were uninsured. Among those adults, 68% said they were uninsured because they lost their job or were unable to afford coverage (Figure 1). The uninsured are more likely than the insured to forgo needed medical care, which increases the risk of developing serious health conditions. If the uninsured later obtain employer-sponsored coverage, these pre-existing conditions may not be completely covered. Those without health coverage are also more likely than the insured to incur medical debt, which poses an additional challenge to the unemployed facing precarious financial situations.

This policy brief outlines the challenges facing the unemployed as they seek to remain insured. Some of the

unemployed may have the option to switch to a spouse's employer-sponsored insurance. The unemployed who had employer-sponsored coverage while employed may have the opportunity to continue this coverage through COBRA. The unemployed can also purchase coverage in the non-group market, but high premiums in this market make this option unattainable for many unemployed individuals who also struggle with reduced income. Some unemployed individuals may qualify for public coverage, such as Medicaid, but many do not meet current eligibility requirements. The Patient Protection and Affordable Care Act of 2010 (ACA) will increase coverage options for the unemployed through an expansion in Medicaid and subsidizing coverage purchased in the Health Insurance Exchanges, though most coverage provisions do not take effect until 2014.

Figure 1
Health Coverage of Unemployed Adults and Their Reasons for Being Uninsured, 2009



Analysis of adults age 18-64 who said that they were not working but were looking for work in the week prior to being surveyed.
SOURCE: KCMU analysis of 2009 NHIS data

Dependent Coverage

Some unemployed individuals may have the option to enroll in family coverage through their spouse's employer-sponsored insurance plan. However, the unemployed may find premiums for family coverage are prohibitively expensive given the household's reduced income. In 2010, the average annual premium for employer-sponsored family coverage was \$13,770, as compared to \$5,049 for individual coverage.³ In addition, employers often contribute less to premiums for family coverage than for individual coverage. On average employers paid 70% of premiums for family coverage and 81% of premiums for individual coverage.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) included provisions to help people continue their employer-sponsored health coverage after leaving a job. Typically, employers and employees share the cost of employer-sponsored coverage. Under COBRA, recently unemployed adults continuing their employer-sponsored coverage are required to pay the entire premium plus an administrative fee to maintain coverage. The American Recovery and Reinvestment Act of 2009 (ARRA) included a temporary COBRA subsidy to defray the high cost of premiums, but the subsidy is no longer available for the newly unemployed.

Eligibility for COBRA

COBRA provides employees and their dependents the opportunity to continue purchasing health insurance through their former employer for up to 18 months after they would otherwise have lost coverage due to a layoff, divorce, or another qualifying event.⁴ Employees who lose their job because their employer goes out of business cannot qualify for COBRA, as their employer-sponsored health plan is no longer available. Similarly, if an employer stops offering health insurance to all of its workers, those workers are not eligible for COBRA because there is no health plan to continue.

Not all employees are eligible for COBRA. Under federal law, eligible individuals must have had employer-sponsored coverage from a company with the equivalent of 20 or more full-time workers. Thirty-nine states and the District of Columbia have enacted continuation coverage laws (also known as "mini-COBRA" laws) requiring employers with fewer than 20 employees to provide recently unemployed workers with the opportunity to continue employer-sponsored coverage. Some states' mini-COBRA laws mirror the federal COBRA law, but others provide more limited benefits or shorter periods of continued coverage. Workers in lower income households are more likely to work for small firms and are therefore less likely to be eligible for federal COBRA coverage.⁵

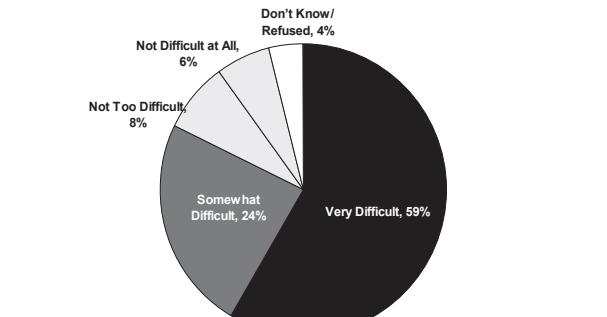
Cost of COBRA

The original COBRA legislation required recently unemployed adults that continue their employer-sponsored coverage to pay 102% of the health insurance premium. The additional 2% of the premium addresses the administrative costs associated with continuing coverage. In 2010, the total annual premium of employer-sponsored health insurance averaged \$5,049 for an individual policy and \$13,770 for a family policy.⁶ Converting this to a monthly COBRA payment, the average premium for individuals would be \$429, and the average premium for families would be \$1,170.

COBRA premiums may be prohibitively expensive for unemployed individuals, given their loss of income. A 2009 Kaiser Family Foundation survey found that nearly 83% of employees said they would find it somewhat or very difficult to pay the full cost of their employer-sponsored insurance premiums if they became unemployed (Figure 2).

In 2009, Congress recognized the challenge facing individuals who pay for COBRA while also facing declining incomes. ARRA included a nine-month federal subsidy covering 65% of the cost of COBRA for employees that were involuntarily terminated between September 1, 2008 and December 31, 2009. That provision was later extended to those laid-off between January 1, 2010 and May 31, 2010, and the duration of the subsidy was lengthened to 15 months. Based on the average total premiums for employer-sponsored coverage, the monthly COBRA cost with the subsidy in 2010 would be approximately \$150 for individuals and \$410 for families.⁷

Figure 2
Difficulty of Paying for COBRA Among Individuals with Employer-Sponsored Insurance, 2009



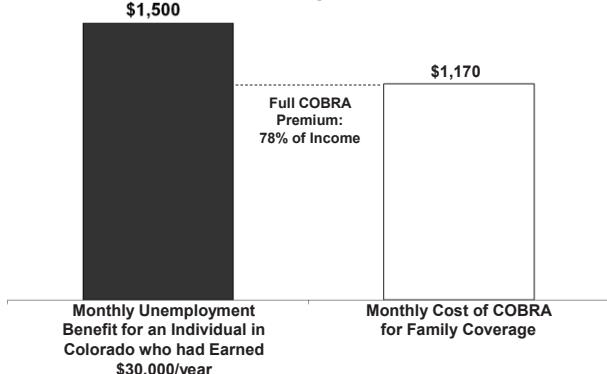
Respondents were asked how difficult it would be to pay for the full cost of employer-sponsored coverage if they or their spouse (if the respondent was insured through the spouse's employer) lost their job.

SOURCE: Kaiser Health Tracking Poll, February 3-12, 2009 (#7867)

Case Example: A Single Mother in Colorado

A single mother in Colorado that lost a job earning \$30,000 annually would qualify for approximately \$1,500 a month in unemployment insurance benefits to meet her family's basic needs.⁸ Assuming her employer-sponsored coverage had premiums equal to the national average, COBRA would cost her \$1,170 a month for family coverage or \$429 for individual coverage. These premiums are 102% of the average monthly premium of employer-sponsored coverage. In order to retain insurance coverage for her family after losing her job, she would spend 78% of her income on COBRA coverage. If she decided to retain coverage for herself and not her children, she would spend 29% of her income on an individual COBRA policy. These costs estimates do not include co-insurance that may be required to receive treatment or medication.

Cost of COBRA Coverage Compared to Income from Unemployment Benefits, 2010



SOURCE: Colorado Internet Unemployment Claims System, Kaiser/HRET Employer Health Benefits Survey, 2010.

There are conflicting estimates of the number of people who benefited from the ARRA COBRA subsidy. In February of 2009, the Joint Committee on Taxation predicted that approximately seven million people would benefit from the subsidy for some portion of 2009.⁹ The next year, the Treasury Department found that approximately two million households benefited from the subsidy in 2009, although the analysis utilized data from employer filings and may have double counted some former employees.¹⁰ A second estimate, based on a national survey, found that the number of non-working adults with coverage through a former employer increased by approximately 700,000 between December 2008 and August 2009.¹¹ It may be that uptake of the subsidy was lower than originally predicted because the unemployed found even reduced COBRA premiums unaffordable.

Coverage in the Non-Group Market

Unemployed adults that are unable to afford COBRA, or whose COBRA coverage expired, may attempt to purchase non-group health insurance directly from health plans or through a broker. Generally, those purchasing insurance policies in the non-group market face increased administrative barriers, more limited coverage, and higher premiums than those enrolled through employer-sponsored plans. Because of these characteristics of the non-group market, unemployed individuals purchasing coverage in the non-group market may face difficulty obtaining coverage comparable to what they had through their previous employer. The ACA includes a number of changes to address these problems, though many of these provisions will not be implemented until 2014.

Coverage Purchased in the Non-Group Market Prior to the ACA

In most states, insurance companies can adjust premiums for non-group insurance plans based on the applicants' individual factors, such as age, gender, or health status. People with previous health conditions may pay more for insurance coverage purchased in the non-group market than for comparable employer-sponsored plans. In some cases, insurers may consider older applicants or those with pre-existing conditions to be poor risk and deny coverage altogether. Insurance policies purchased in the non-group market also may be more limited than employer-sponsored plans. For example, many states allow non-group policies to exclude coverage for maternity care or limit prescription drug coverage. Deductibles and other cost sharing in non-group plans may also be higher than in employer-sponsored coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides limited federal protections for adults purchasing non-group coverage. The law mandates that each state have at least one health plan that accepts applicants meeting the following criteria: previously insured for 18 months and most recently had group coverage, exhausted COBRA, not eligible for a group or public insurance plan, and uninsured for less than 63 days.¹² Some states have established limits on premiums for this coverage, though there are no federal limits.

Thirty-four states also operate high-risk pool plans to offer health insurance to residents who, because of pre-existing conditions, are unable to purchase affordable coverage in the non-group market.¹³ These high-risk plans typically charge higher premiums than coverage offered to the general public and may require a two to twelve month waiting period.¹⁴

Changes to the Non-Group Market in the ACA

The ACA makes substantial changes that aim to reduce barriers to purchasing insurance in the non-group insurance market. Some changes took effect soon after enactment, such as extending dependent coverage for adult children up to age 26 for all individuals and group policies. However, most major reforms will not be implemented until 2014. These changes may provide more affordable coverage options to the long-term unemployed who currently are unable to purchase coverage in the non-group market or through COBRA.

Under a program started in 2010, people with pre-existing conditions who have been uninsured for at least six months are eligible to purchase coverage from a Pre-existing Condition Insurance Plan (PCIP). The ACA requires that these plans calculate premiums based on the general health of the population, instead of adjusting premiums based on an applicant's health status. Some unemployed individuals may take advantage of the PCIP, but others may find that they are ineligible because they have not been uninsured for six months or the premiums remain unaffordable. The initial assessment from the Congressional Budget Office estimated that 200,000 people would enroll in the PCIP program.¹⁵ As of March 2011, just over 18,000 people had signed up.¹⁶

Starting in 2014, people will be able to purchase coverage through Health Insurance Exchanges. To make coverage more affordable, premium and cost-sharing subsidies will be available for most people without access to affordable employer-sponsored insurance and with incomes up to 400% of the federal poverty level (FPL). (In 2011, 400% FPL was \$43,560 for an individual and \$89,400 for a family of three.) The premium subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5% of income for those between 300% and 400% of the poverty level (Table 1).

Table 1: Premium Tax Credits for Coverage through Health Insurance Exchanges, by Income as a Share of FPL	
Income Level*	Premium as a Percent of Income
Up to 133% FPL	2% of income
133 - 150% FPL	3 - 4% of income
150 - 200% FPL	4 - 6.3% of income
200 - 250% FPL	6.3% - 8.05% of income
250 - 300% FPL	8.05% - 9.5% of income
300 - 400% FPL	9.5% of income

* In 2011, 100% of the federal poverty line (FPL) is \$10,890 for an individual and \$18,530 for a family of three

The ACA also includes new insurance regulations to improve the scope and availability of coverage offered in the non-group market. Health insurance plans are no longer permitted to have lifetime dollar value caps on benefits and limits annual caps. Insurers will also no longer be allowed to vary premiums or deny coverage based on health status. Starting in 2014, insurance plans sold to individuals and small employers must cover an essential benefits package, including (among other services) ambulatory and emergency care, hospitalizations, maternity and newborn care, and prescription drugs. The Secretary of Health and Human Services will determine additional specifications of the essential benefits package.

Public Coverage Options

Medicaid and the Children's Health Insurance Program (CHIP) have provided an important source of coverage, particularly for children, during the recent economic downturn. Medicaid now covers nearly 60 million people, including 1 in 3 children. Nearly 600,000 fewer children were uninsured in 2009 than in 2007, as 4.6 million children gained Medicaid or CHIP coverage.¹⁷

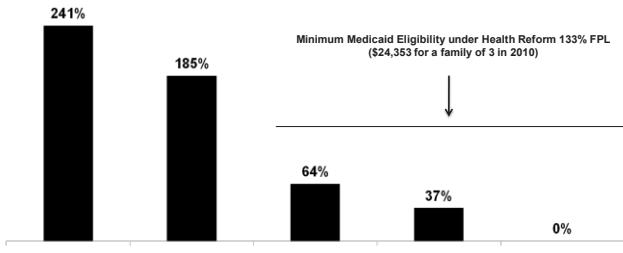
Despite the country's continued economic problems, nearly all states' Medicaid and CHIP eligibility rules remained stable or made targeted improvements in 2010.¹⁸ Stability in the public programs can be directly attributed to provisions in the ARRA that required states to maintain their Medicaid eligibility rules and enrollment procedures as a condition of receiving a significant, temporary increase in the federal Medicaid matching rate. The ACA also included a maintenance-of-effort (MOE) requirement designed to keep Medicaid coverage steady for adults until broader reform goes into effect in 2014 and for children until 2019, as well as to extend these protections to children covered by CHIP. Without the MOE requirements and enhanced federal funding, many states almost certainly would have needed to turn to cutbacks in coverage in 2010 as a result of continuing budget pressures. However, under current Medicaid eligibility rules, many low-income individuals remain ineligible for coverage. The ACA will broadly expand Medicaid eligibility in 2014, providing an important new coverage option for many low-income adults. This expansion will increase the ability of Medicaid to serve as a safety net for the low-income unemployed.

Current Medicaid eligibility requirements vary significantly across states and groups. To participate in Medicaid and receive federal matching funds, states must cover certain groups of individuals, including children, pregnant women, parents, elderly individuals, and individuals with disabilities up to specified minimum income levels. States can also choose to cover these groups up to higher income levels with federal matching funds. Prior to the passage of the ACA, low-income non-disabled adults without dependent children were not included in the groups states could cover through the Medicaid program with federal dollars. As such, states could only cover these adults through a waiver or fully state-funded program. The ACA provided states a new option, effective April 2010, to receive federal funds to cover low-income non-disabled adults without dependent children with incomes up to 133% FPL.

Through Medicaid and CHIP, all states have expanded coverage to children well beyond the federal minimum levels, creating a strong base of coverage for low-income children (see Figure 3).

However, many poor adults, particularly adults without dependent children, remain ineligible for Medicaid. Further, in many states, eligibility thresholds for jobless parents are lower than levels for working parents. This difference arises because rules that allow working parents to disregard a portion of their earnings (e.g., income that goes to work-related

Figure 3
Median Medicaid/CHIP Eligibility Threshold for Children, Pregnant Women, Parents, and Non-Disabled Adults, January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

expenses such as transportation or child care costs) when determining eligibility do not apply to jobless parents. Eligibility for non-disabled adults without children is even more limited than that for parents, with only eight states, including DC, providing Medicaid or Medicaid-equivalent coverage to these adults.¹⁹ A number of states provide more limited coverage to parents and other adults up to higher income limits through waivers or state-funded programs, but this coverage has fewer benefits and/or higher cost sharing requirements than Medicaid and is often subject to an enrollment cap.

Given current eligibility rules, many unemployed parents may find that their children qualify for Medicaid or CHIP, but they do not qualify themselves. Income from their unemployment benefits may make them ineligible but may not be enough to purchase private insurance coverage. Moreover, reflecting their historic exclusion from the program, in most states, other non-disabled low-income unemployed adults remain ineligible for Medicaid regardless of their income.

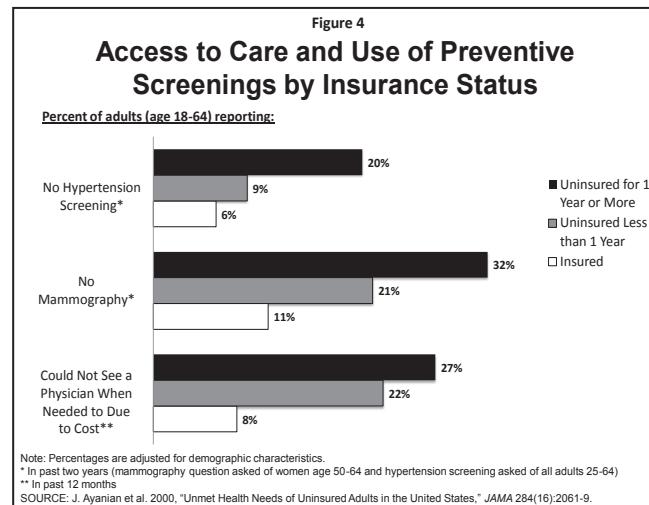
In 2014, ACA will expand Medicaid eligibility to a national minimum eligibility floor of 138% of poverty across all groups (\$14,484 for an individual and \$24,646 for a family of three in 2011).²⁰ This expansion will significantly increase Medicaid eligibility for parents and other adults in many states beyond the 2010 option and create a new coverage option for low-income long-term unemployed individuals.

Consequences of Lapses in Coverage

Individuals who remain uninsured while looking for work risk both their health and financial security. Compared to insured adults, uninsured adults are significantly less likely to receive recommended screenings and more likely to go without a needed physician visit due to cost (Figure 4). These barriers to access occur when adults are uninsured for less than a year and increase when uninsured for a longer duration.

Uninsured individuals seeking treatment may have trouble accessing care when they are sick. Most health providers are not required to provide care to the uninsured. Federal law only requires emergency departments to screen and stabilize all individuals. Uninsured patients unable to pay in full for treatment may be turned away when seeking follow-up care.²¹

Further, uninsured patients who receive care are typically charged for that care, often paying higher charges than the insured.²² Unpaid bills may lead to medical debt for the unemployed, who may already struggle to pay daily expenses with limited income. If the uninsured are unable to access treatment or forgo care in order to avoid medical debt, their health problems may worsen, which makes rejoining the workforce more difficult.²³



Even after regaining employer-sponsored coverage, gaps in coverage continue to have repercussions. Currently, if an adult is uninsured for 63 days or more, pre-existing condition exclusions can be imposed by their new health plan for most health conditions for which treatment, advice, or diagnosis were received in the six months prior to enrolling in an employer-sponsored insurance plan.²⁴ As of 2010, the ACA prohibited plans from denying or restricting coverage for children who have a pre-existing condition. Beginning in 2014, health plans will also be prohibited from restricting coverage or charging higher premiums for adults with pre-existing conditions.

Outlook

The continuing weak job market may leave many individuals unemployed for long periods of time. Over six million workers have been unemployed for six months or more and have limited options to remain insured. However, the ACA will soon offer new and more affordable coverage options for the unemployed through an expansion of the Medicaid program and the creation of Health Insurance Exchanges with subsidized insurance to facilitate the purchase of private coverage. These reforms will provide the unemployed with more affordable options for remaining insured after losing employer-sponsored coverage.

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