Health Insurance Portability: COBRA Expansions and Job Mobility

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Issue Brief

- This *Issue Brief* discusses continuation-of-coverage mandates under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It provides background information on health insurance portability and job mobility, data on the cost to employers of providing continuation of coverage to former employees, and a summary of empirical research on COBRA's effect on employee benefits and job mobility.

- COBRA coverage can be considered advantageous for most workers, as it allows continuation of the health insurance policy they had in place at work when they lose or leave a job. Although employees can be required to pay 102 percent of the premium for COBRA coverage, they can usually realize significant savings compared with the cost of purchasing the equivalent insurance policy in the private market.

- Many employers consider COBRA to be a costly mandate for three reasons. First, premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered. Second, COBRA imposes an additional administrative cost on employers. Third, many employers view the penalties for noncompliance as excessively large.

- According to a survey conducted by Charles D. Spencer & Associates, of the 10.2 percent of employees and dependents who were eligible for COBRA coverage in 1996, over 28 percent elected it. In addition, average employer claims costs for COBRA beneficiaries amounted to $5,591, compared with $3,332 for active employees in surveyed plans.

- According to Employee Benefit Research Institute estimates of the Survey of Income and Program Participation (SIPP), the COBRA population is much older than the general insured population. COBRA beneficiaries also have higher personal income than the general insured population, with this difference being almost entirely due to differences in retirement income.

- Any attempt to expand COBRA coverage, either through subsidies or by allowing workers to choose from plans with lower premiums, would likely result in increased employer health care costs. As a result, employers may consider various alternatives to reduce, shift, or eliminate the impact of this increased cost. One alternative would be to continue requiring active employees to share in the increased costs through higher employee contributions. A second alternative would be to reduce or eliminate health care benefits for active employees and/or future retirees and their families. A third alternative would be to reduce the size of the work force eligible for health insurance benefits. Finally, employers may pass additional costs on to workers or consumers.

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Introduction

Health care reform has been on the nation's agenda for decades. In 1948, President Truman's proposal for national health insurance would have provided subsidies to all individuals regardless of income level. President Nixon had his own proposal for national health insurance, and was responsible for the passage of the Health Maintenance Organization Act in 1973. As recently as 1992, the Bush administration proposed to reform the small group health insurance market and provide for refundable tax credits and vouchers to purchase health insurance (Custer and Foley, 1992). The Clinton health plan, like its predecessors, would have guaranteed, among other things, that all Americans have health insurance coverage, that unemployed individuals and their families would not go without coverage, and that individuals with preexisting conditions would be able to obtain health insurance coverage. The failure of this plan in 1994 shifted the policy focus from universal reform to incremental changes to the U.S. health care system. Legislation enacted since the Health Security Act of 1994 failed has largely affected insured individuals. With the exception of legislation designed to cover more uninsured children, virtually nothing has been passed addressing the uninsured or health insurance portability.

Health insurance would be totally portable if a worker did not have to change health plans on job change. To understand portability, a brief examination of pension plans is helpful. All pension plans are portable in that they allow "vested" workers to keep accumulated assets on job change. For example, if a worker with a defined contribution plan changes jobs, the amount accumulated in the worker's account can be rolled over into a qualified individual retirement account (IRA), and, in some cases, to the new employer's pension plan.[1]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established greater portability of health insurance, prohibiting group health plans from imposing preexisting condition exclusion periods on individuals with a history of prior health insurance coverage. HIPAA does not ensure that a worker who changes jobs will have access to health insurance coverage on the new job, and does not ensure the affordability of health insurance on the new job. In addition, HIPAA does not allow individuals to maintain the *same* group health plan after a job change. When a worker changes health plans on job change, it is highly likely that he or she may have to change health care providers and that the new benefits package will be different. Therefore, "total" portability has not been achieved. HIPAA did make incremental changes that make health insurance more affordable for the self-employed by increasing the tax deductibility of health insurance premiums. Other examples of legislation enacted that applies only to insured individuals includes the Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996.

After passage of the Balanced Budget Act of 1997, many parties are asking, "what next?," some with anticipation, others with concern. A quick history lesson indicates that the Clinton administration has previously proposed, as part of prior budget proposals, providing subsidies for health insurance to unemployed individuals.[2] In addition, many members of Congress have had a long history of support for expansions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which allows employees and their families to continue health insurance coverage after a job loss or job change (Custer and Foley, 1992). COBRA subsidies could

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[1] *For workers with a defined benefit (DB) plan, job change may result in a loss of potential benefits. DB plans typically base benefits in part on years of service. As a result, workers who change jobs may not be credited for past service with former employers. In addition, full vesting of pension benefits does not usually occur immediately for plan participants.*

[2] *See Fronstin (1995) for previous discussions of the Clinton administration proposal as well as other proposals to expand federal continuation-of-coverage mandates.*

also be used to expand health insurance coverage among the uninsured population ages 55–64.[3] Numerous proposals have been set forth, but never enacted, to ensure continued health insurance coverage for unemployed individuals by subsidizing the cost of health insurance coverage through a former employer. In addition, the Clinton administration recently proposed an expansion of COBRA coverage for retirees whose former employer has dropped retiree health benefits.

This *Issue Brief* discusses issues surrounding continuation-of-coverage mandates. While many workers benefit from these mandates, they are costly. The first section provides background information on health insurance portability and job mobility. The following section provides data on the cost of providing continuation of coverage through a former employer and other relevant data. The final section includes a summary of empirical research on employee benefits and job mobility.

Background Issues

Job-Lock

Concern about portability of health insurance arises in situations in which a worker is leaving, or would like to leave, a job and during periods of unemployment and labor force withdrawal. Concerns also arise when a worker is unemployed or retires prior to Medicare eligibility (age 65) and desires "bridge" coverage. In addition, portability could help alleviate the loss of insurance benefits when a worker is offered a new job that could alter his or her insurance status. Workers may remain with current employers for a number of reasons—a prospective employer may not offer health insurance; a waiting period may be required before an employee becomes eligible for coverage; the prospective employer's benefits package may be less generous; and/or the worker (or a dependent) may have a preexisting condition that would not be covered under the plan. These scenarios may result in "job-lock," or in employees forgoing job opportunities that could potentially increase their productivity and income.[4] In other words, workers may forgo job opportunities in which a better match between the worker and the employer would enable the worker to perform his or her job more effectively. For employers that want employees to leave or retire, and for employees who would prefer to change jobs, job-lock can be undesirable.

Continuation of Coverage

Policymakers originally dealt with the issue of health insurance portability and job-lock when COBRA was passed.[5] COBRA was effective for plans years beginning July 1, 1986. The goal of COBRA coverage was to relieve the hardships experienced by employees and their families resulting from the temporary loss of group health insurance by providing a transition period to other coverage (Millholland, 1992). COBRA requires employers with health insurance plans to offer continued access to group health insurance to qualified beneficiaries if they lose coverage as a result of a qualifying event. COBRA requires continued access for 18 months (or 29 months if the qualified beneficiary is disabled) for covered employees, spouses, and dependent children who lose coverage when a covered employee terminates employment (for reasons other than gross misconduct) or if the worker's hours are reduced. COBRA requires continued access for 36 months for spouses and dependent children who lose coverage as a result of a covered

[3] *Any attempt to address the uninsured population by covering the population ages 55–64 would have limited effect. The population ages 55–64 comprises 3.0 million, or 2.3 percent, of the 41.4 million uninsured Americans in the United States in 1996 (Fronstin, 1997). In contrast, uninsured children account for 25 percent of the uninsured.*

[4] *Evidence of job-lock is presented later in this* Issue Brief.

[5] *COBRA was actually signed into law on April 7, 1986.*

employee's death, divorce, or legal separation. In addition, spouses and dependent children qualify for continued access for 36 months if a covered employee becomes eligible for the Medicare program.

The coverage offered must be identical to that available prior to the change in the worker's employment status. The qualifying employee or dependent may be required to pay up to 102 percent of the premium (disabled qualified beneficiaries may be required to pay up to 150 percent of the premium for months 19 through 29). Group health plans for public and private employers with fewer than 20 employees are excluded from these provisions, as are plans offered by churches (as defined in sec. 414(e) of the Internal Revenue Code); the District of Columbia; or any territory, possession, or agency of the United States.

Many states had already passed continuation-of-coverage laws prior to enactment of COBRA. These statutes, summarized in table 1, generally extend coverage for between three and six months.[6] The effects of these laws were seriously compromised by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA supersedes all state law that is otherwise applicable to employee benefit plans. Hence, an employer can avoid any state regulation of its health plan by self-funding, or self-insuring, the health plan. As a result, the employers required to comply with state continuation-of-coverage laws were mostly small ones, because many large employers were exempt due to "ERISA preemption."

Table 1
State Continuation-of-Coverage Laws

State	Effective Date	Months of Coverage
Arkansas	7/20/79	4
California	1/1/85	3
Colorado	7/1/86	3
Connecticut	10/1/75	10
	1/1/87	20
Georgia	7/1/86	3
Illinois	1/1/84	6
	8/23/85	9
Iowa	7/1/87	9
Kansas	1/1/78	6
Kentucky	7/15/80	9
Minnesota	8/1/74	6
	3/19/83	12
	6/1/87	18
Missouri	9/28/85	9
Nevada	1/1/88	18
New Hampshire	8/22/81	10
New Mexico	7/1/83	6
New York	1/1/86	6
North Carolina	1/1/82	3
North Dakota	7/1/83	10
Oklahoma	1/1/76	1
Oregon	1/1/82	6
Rhode Island	/ /88	18
South Carolina	1/1/79	2
	1/1/90	6
South Dakota	7/1/84	3
	3/3/88	18
Tennessee	1/1/81	3
Texas	1/1/81	6
Utah	7/1/86	2
Vermont	5/14/86	6
Virginia	4/17/86	3
Wisconsin	5/14/80	18

Source: Hewitt (1985) and Thompson Publishing Group, 1992, as reported in Jonathan Gruber and Brigitte C., "Health Insurance and Job Mobility: The Effects of Public Policy on Job-Lock, *Industrial and Labor Relations Review* 48(1) October 1994): 86–102.

Advantages and Disadvantages of COBRA Coverage

COBRA coverage can be considered advantageous for most workers, as it allows continuation of the policy they had in place at work. Although an employee can be required to pay 102 percent of the premium for COBRA coverage, workers can usually realize significant savings, compared with purchasing the equivalent health insurance policy in the private market. COBRA premiums are usually lower than insurance plans purchased directly from an insurance company as a result of economies of scale in administering group health insurance and the reduced risk of adverse selection.[7] Furthermore, employment-based health insurance typically covers a larger array of benefits than individually purchased health insurance for an equivalent premium. Consequently, COBRA coverage is a "better buy" than a plan purchased in the individual market.

COBRA coverage can be considered even more beneficial for older workers. Consider the following

[6] *Table 1 does not include some of the state laws pertaining to continuation of coverage that were passed after the passage of COBRA in 1986.*

[7] *Adverse selection occurs when higher-risk individuals are more likely to* seek health insurance coverage than lower-risk individuals.

Premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered because of adverse selection.

example of a small firm with a traditional fee-for-service health plan offered by Blue Cross Blue Shield in the Washington, DC, region for plan years starting March 1, 1995. Under the health plan, the annual premium for all workers with a family plan was $10,859. However, the actuarial cost of the plan varied greatly across workers. The actuarial cost for family coverage for workers under age 30 was $4,524, while the actuarial cost for workers ages 55 and older was $12,759. If a worker chooses COBRA coverage, the premium would be $11,076, or 102 percent of the annual premium. Young workers have an incentive to forgo COBRA coverage, while older workers have an incentive to accept COBRA coverage. As a result, the COBRA coverage pool of insured workers is adversely selected—meaning only relatively older and unhealthy individuals will choose COBRA coverage, and the cost of providing health insurance coverage will increase for all workers.

If a firm is fully insured through an insurance company or a health plan, the cost of adverse selection, to the degree that it exists, may be shifted from the company to the insurer or health plan.[8] However, insurers may price their products higher in order to avoid bearing the cost of adverse selection. Similarly, if a firm is self-insured, its costs would increase because it would receive $11,076 from each COBRA-covered worker, but would expect to pay $12,759 in claims for each COBRA-covered worker age 55 and older. COBRA essentially shifts the cost of uncompensated health care from the public sector to the private sector because it reduces the level of that burden that typically falls on health care providers and other payers (Custer and Foley, 1992).

Many employers consider COBRA to be a costly mandate for three reasons. First, premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered because of adverse selection. Second, COBRA imposes an additional administrative cost on employers. Not only do employers have to administer the plan; they must also find and notify COBRA-eligible individuals. This process could be costly, especially notification of divorced and separated spouses and other dependents. While health plans are allowed to charge 102 percent of the cost of the health plan, the additional 2 percent may not fully cover these administrative costs. Third, many employers view the penalties for noncompliance as excessively large (Long and Marquis, 1992).

COBRA Expansion and Alternatives to Expansion

Assuming that individuals electing COBRA coverage are a relatively higher risk population than the general work force, any expansion of the current law that affects either the size of the firm covered under COBRA or the length of time that former workers are eligible for continuous coverage would almost certainly increase employer costs for health insurance. In addition, subsidies for COBRA coverage, as previously proposed by the Clinton administration, would increase the percentage of eligible workers electing COBRA coverage. While this might reduce the degree of adverse selection if individuals previously at the margin because of low expected health care costs accepted COBRA coverage, it would still drive up the overall claim costs for employers, especially self-insured employers. One alternative to mitigate higher health care costs would be to allow workers to choose from plans that are similar to the current plan, such as plans with a high deductible. However, previous research indicates that access to continuation of coverage is not likely to significantly affect the level of the uninsured (Klerman and Rahman, 1992), although there is evidence that the availability of continuation of coverage increases the

[8] *If young workers and older workers are equally likely to have COBRA qualifying events and equally likely to participate in COBRA, then the costs associated with adverse selection are minimized. However, if older workers with above average health care utilization are more likely to elect COBRA coverage, adverse selection will affect health care costs.*

duration of unemployment, suggesting that it allows individuals to spend more time in "productive" job searches (Gruber and Madrian, forthcoming). Some of this effect may be due to state-mandated continuation-of-coverage laws and the existence of dual labor markets.[9]

Another alternative would be to guarantee access to health insurance coverage either in the individual market or through state-sponsored high-risk insurance pools. HIPAA included provisions for group-to-individual portability for workers who have exhausted COBRA coverage. Under this provision, workers would have an incentive to continue COBRA coverage in order to qualify for coverage in the individual market. As mentioned above, this is costly to both employers and workers. In order to reduce costs to employers and workers, COBRA could be repealed and group-to-individual portability guaranteed at the time that a worker leaves an employer. This, however, would have the effect of "shifting" the cost of continuation-of-coverage mandates from employers and workers to insurance companies in the individual market, and ultimately, to individuals covered in this market. Thus, any expansion in continuation-of-coverage mandates either through COBRA or through increased access to insurance in the individual market will increase costs to workers, employers, or insurers.

HIPAA also includes a provision to encourage states to provide medical coverage for high-risk individuals by granting tax-exempt status to organizations that establish high-risk insurance pools. These pools would be open to individuals with preexisting conditions. If individuals were to enroll in these pools instead of taking COBRA coverage, the burden of adverse selection would no longer fall on employers. It should be noted, however, that state-sponsored high-risk pools have not been effective in covering a significant portion of the population, in large part due to high premiums. Hence, any attempt to use these pools for health insurance portability may yield mixed results.

[9] *The dual labor market theory suggests that there are two noncompeting labor markets: a primary sector that offers relatively high wages and stable jobs that include employee benefits and a secondary sector that tends to be low wage and unstable. This theory indicates that workers with health insurance who change jobs are likely to get another job with health insurance, but workers without health insurance tend not to gain health insurance on job change (Doeringer and Piore, 1971).*

Table 2
Continuation-of-Coverage Entitlement and Elections under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Plan Years, 1988-1996

Plan Year	Employees/ Dependents Who Elected COBRA as a Percentage of Active Employees	Employees/ Dependents Entitled to COBRA as a Percentage of Active Employees	Employees/ Dependents Who Elected COBRA as a Percentage of Those Entitled
1988	1.7%	16.0%	11.2%
1989	2.6	9.2	28.5
1990	2.2	10.6	20.5
1991	1.6	12.1	13.2
1992	1.7	8.7	19.3
1993	2.9	14.5	19.6
1994	1.3	7.2	18.2
1995	2.2	11.4	19.2
1996	2.3	10.2	28.1

Source: Charles D. Spencer and Associates, Inc., "1995 COBRA Survey: *Spencer's Research Reports* (Chicago, IL: August 25, 1995); 329.04.-1; and Stephen A. Huth, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Reivew* (September 1997): 36–44.

COBRA Costs and Elections

Several surveys have been conducted regarding issues surrounding the use of COBRA. A survey conducted in the spring of each year by Charles D. Spencer & Associates, Inc., covering 1.42 million workers in approximately 200 firms, has typically yielded consistent answers about COBRA coverage (Charles D. Spencer & Associates, 1995; and Huth, 1997). Some key results of the survey include the following:

- Of the 10.2 percent of employees and dependents eligible for COBRA coverage, over 28 percent elected COBRA coverage in 1996, up from 19 percent in 1995 (table 2).
- Among all spouses and dependents eligible for coverage, 15.4 percent elected coverage in 1996. This is considerably lower than the percentage of workers electing coverage (27.9 percent).
- Among the entire surveyed population, 2.3 percent of the active employee work force elected COBRA

coverage in 1996 (table 2).

- Among all eligible individuals electing coverage, 12 percent were spouse or dependent elections in 1996, with 6.3 percent electing coverage because of death, divorce, or plan eligibility changes, and 5.8 percent electing coverage because of job termination or reduction in hours of work (table 3).
- Average employer claims costs for COBRA beneficiaries were $5,591, compared with $3,332 for active employees in surveyed plans in 1996. Thus, average continuation-of-coverage costs were 156 percent of the active employee claims costs. Large differences between active employee costs and COBRA costs have been typical since 1990, when average active employee costs were $2,769, compared with $4,208 for COBRA costs (chart 1).
- Costs of COBRA coverage to companies with employees electing coverage vary greatly. Data indicate that within the 1996 plan year, COBRA costs bore little relationship to active employee costs (chart 2).
- For 18-month qualifying events, the average length of coverage was 10.3 months. For 36-month qualifying events, the average length of coverage was 23.1 months. Among individuals electing coverage, just 0.7 percent converted to an individual policy in 1996.
- Difficulties surrounding COBRA coverage, according to surveyed employers, include those related to collecting premiums (37 percent); administrative difficulties and paperwork (22 percent); adverse selection (18 percent); and notification from continuee of election or change in status (15 percent).

It is important to have accurate information on the use of COBRA as a basis for designing effective public policy that improves health insurance portability and job mobility. A study by Long and Marquis (1992) found some evidence that COBRA beneficiaries used more health care than active workers. They studied claims data from three large employer health plans, and found that COBRA health care costs ranged from 32 percent to 224 percent higher than costs for active workers. For one plan, these differences were due entirely to demographics, with COBRA beneficiaries being much more likely to be women of childbearing age. These data would suggest that allowing employers and insurers to set COBRA premiums based on risk-adjusted factors, such as demographics, would reduce the level of adverse selection.

Table 3
Reasons for Continuation-of-Coverage Elections under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Plan Years, 1990-1996

		Spouse/Dependent Election		
Plan Year	Total Electing Coverage	Termination or Reduction in Hours	Death, Divorce, Plan Ineligibility	Termination or Reduction in Hours
1990	100.0%	16.0%	7.6%	76.4%
1991	100.0	10.2	8.3	81.6
1992	100.0	15.0	13.5	71.5
1993	100.0	7.9	8.0	84.1
1994	100.0	4.4	17.5	78.0
1995	100.0	11.5	7.5	81.0
1996	100.0	5.8	6.3	87.9

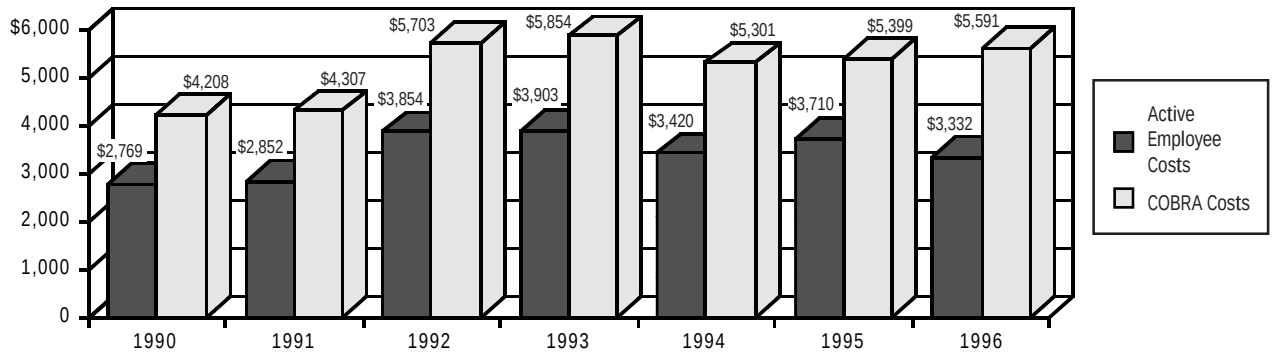
Source: Stephen A. Hugh, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Review* (September 1997): 36–44.

In terms of the size of the COBRA population, Flynn (1992) examined data from the August 1988 Current Population Survey and found that at least 821,000 individuals had COBRA coverage. An additional 496,000 had COBRA coverage as dependents. One shortcoming of this estimate is that it only includes individuals ages 40–64 because the survey was designed to gather information on retiree health insurance. Therefore, the estimate of the actual number of individuals with COBRA coverage is likely to be much higher. Since the question used to determine COBRA coverage did not distinguish between COBRA coverage and retiree health insurance, the author had to make some assumptions about the data.

When examining selected demographics of the COBRA population, Flynn found that 67 percent were in families with less than $25,000 in family income. This brings into question whether some of the 821,000 with COBRA coverage really had retiree health insurance, because COBRA coverage is very expensive and could represent as much as 8 percent of income for a person in a family with family income of $25,000.[10] As a percent-

[10] *This figure is based on data from A. Foster Higgins, which indicate that the average cost for health insurance from a large employer in 1988 was $1,911.*

Chart 1
Seven Years of Adverse Selection: Average Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Costs per Participant, Plan Years 1990–1996



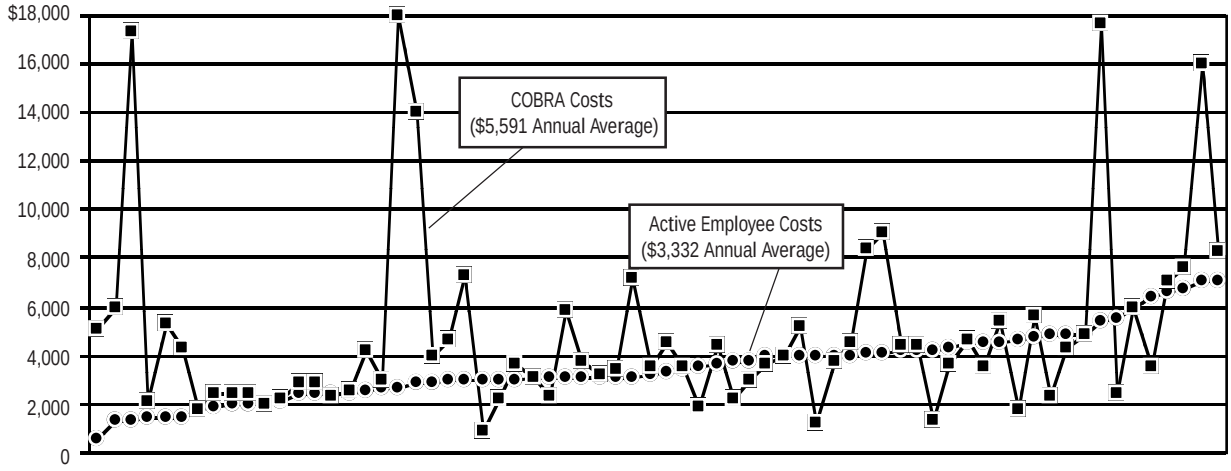
Source: Stephen A. Hugh, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Review* (September 1997): 36–44.

age of income, COBRA coverage would be even higher for lower-income families. Flynn also found that 16 percent of COBRA beneficiaries were working, 16 percent were unemployed, and 67 percent were not participating in the labor force. This may further support the idea that some of the COBRA beneficiaries were actually covered by retiree health insurance, although it may also indicate that they were using COBRA as a bridge to Medicare coverage. Since most of the COBRA population examined was unemployed, most of this population was unaffected by the lack of health insurance portability and job-lock. Flynn also presents data on qualifying events and elections, based on data from Applied Benefits Research, the largest administrator of COBRA benefits in the United States, showing that take-up rates are consistent with those in the COBRA survey conducted by Charles D. Spencer & Associates, Inc.

COBRA Beneficiaries

While there are data on COBRA elections and limited data on the size of the COBRA population, virtually no data exist on COBRA beneficiaries themselves. For policy purposes, it is important to understand the characteristics of the COBRA population and how this

Chart 2
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Costs Compared with Active Employee Costs, 1996



Source: Stephen A. Hugh, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Review* (September 1997): 36–44.

The COBRA population is much older than the population of individuals with employment-based coverage through their current employer.

population differs from the rest of the population. In order to gain a better understanding of the COBRA population, we use data from the 1993 panel of the Survey of Income and Program Participation (SIPP). SIPP is a longitudinal study that follows individuals for 36 months. Combining waves 6–9 of the 1993 panel allows us to observe individuals over a 12-month period. This 12-month period, October 1994–September 1995, represents the most recent SIPP data that allow researchers to track the entire sample for 12 months.[11]

Because we are only examining COBRA over a 12-month period, it is impossible to examine the full duration of each spell. Some spells may have begun before October 1994, while others may have ended after September 1995. As a result, we separate COBRA beneficiaries into two groups—those with COBRA coverage for the entire 12 month period, and those with COBRA coverage for less than 12 months—with the understanding that the latter group may in fact have had COBRA coverage for 12 months or longer. Our analysis sample represents 0.6 million individuals with COBRA coverage for 12 months between October 1994 and September 1995, 4.4 million individuals with COBRA for less than 12 months, and 59.2 million individuals with employment-based health insurance coverage in their own name for the entire 12-month period.

As shown in table 4, the COBRA population is much older than the population of individuals with employment-based coverage through their current employer. While we may be capturing a retirement effect, meaning older individuals use COBRA as a bridge to Medicare coverage, we find similar results when limiting the analysis to workers. COBRA beneficiaries are also more likely than individuals with coverage through a current employer to be male, married, white, have no children under age 18, and to have a graduate school education. They are also less likely to be working.

With respect to income, 12-month COBRA beneficiaries have higher personal income than persons with insurance coverage through their current employer (table 5). This is almost entirely due to differences in other personal income, including retirement income. This would suggest that retirees are using COBRA as a bridge to Medicare. However, workers are also more likely to be using other personal income for COBRA coverage. In both cases, the total population and workers had higher average asset income than persons with employment-based coverage through their current employer.

Previous research has been unable to determine what happens to COBRA beneficiaries after COBRA benefits end.[12] Using SIPP, we can determine the health insurance status of COBRA beneficiaries after they leave COBRA. As shown in chart 3, 41 percent of persons ages 18–64 received coverage in their own name from their own employer after leaving COBRA. An additional 12 percent received employment-based coverage as dependents. Ten percent purchased private coverage on their own. Twenty-six percent became uninsured. The same general pattern can be seen for workers leaving COBRA coverage, with 48 percent returning to employment-based coverage in their own name, 9 percent gaining coverage as dependents, 7 percent purchasing private coverage on their own, and 26 percent becoming uninsured.

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[11] SIPP does not allow researchers to make a distinction between retiree health benefits and COBRA coverage. The health insurance question asks respondents to report the source of health insurance coverage, but limits the answers to current employer, former employer, or other. In order to make the distinction between retiree health benefits and COBRA coverage, data from the September 1994 Current Population Survey were used to impute COBRA coverage for individuals ages 40–64. All individuals under age 40 were assumed to have COBRA coverage. SIPP also does not allow researchers to identify spouses and dependents with COBRA coverage; therefore, the population estimates presented in this paper should be considered lower bound estimates.

[12] COBRA benefits end either because the person exhausts the benefits or because he or she stops paying for the benefits before reaching the end of the 18-month benefit period.

Table 4

Characteristics of Persons and Workers Ages 18-64 with 12 Months of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage, Less than 12 Months of COBRA Coverage, and 12 Months of Employment-Based Coverage in Own Name, October 1994-September 1995

	Persons Ages 18–64			Workers		
	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months
Age						
18–24	1%	11%	6%	2%	13%	6%
25–34	5	27	29	7	29	29
35–44	6	23	33	5	24	33
45–54	20	19	23	17	18	23
55–64	68	19	9	69	17	9
Gender						
Male	67	55	59	70	57	59
Female	33	45	41	31	43	41
Marital Status						
Married	76	55	62	79	55	62
Widowed	4	3	2	7	2	2
Divorced	11	14	13	3	12	13
Separated	4	3	3	2	4	3
Never married	6	26	21	9	27	21
Race						
White	94	82	81	94	82	80
Black	5	7	9	4	8	10
Hispanic	1	8	7	2	7	7
Other race	0	3	3	0	3	3
Number of Own Children Under Age 18						
None	93	67	58	89	65	58
One	5	14	17	9	14	17
Two	1	13	17	0	14	17
Three or more	1	6	8	2	7	7
Education						
Some school	12	10	9	7	8	8
High school	36	29	34	33	28	32
College	32	46	43	37	48	44
Graduate school	19	15	15	22	15	16
Household Type						
Married couple	76	61	66	79	62	67
Male head	0	2	3	0	1	3
Female head	9	12	11	5	11	11
Other male	5	13	11	5	12	11
Other female	10	12	9	11	13	9
Group quarters	0	0	0	0	0	0
Number of Jobs						
One job	52	64	95			
Two jobs, all month	2	2	3			
Two jobs, not all month	0	2	0			
Two jobs, no overlap	0	2	0			
No job	46	30	2			

Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.

Table 5

Sources of Income of Persons and Workers Ages 18-64 with 12 Months of COBRA Coverage, Less than 12 Months of COBRA Coverage, and 12 Months of Employment-Based Coverage in Own Name, October 1994-September 1995

	Persons Ages 18–64			Workers		
	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months
Total Income						
Less than $10,000	14%	15%	2%	9%	8%	2%
$10,000–$19,999	24	31	21	15	34	21
$20,000–$29,999	15	24	28	17	25	29
$30,000–$39,999	15	14	21	17	17	21
$40,000–$49,999	7	8	13	7	8	13
$50,000 or more	25	8	16	35	9	16
Earned Income						
Less than $10,000	54	30	2	39	22	2
$10,000–$19,999	17	29	23	22	31	23
$20,000–$29,999	8	19	29	13	22	29
$30,000–$39,999	11	12	20	12	14	21
$40,000–$49,999	1	4	12	2	5	12
$50,000 or more	9	5	15	13	6	14
Asset Income[a]						
Less than $10,000	97	98	99	97	99	99
$10,000–$19,999	1	2	1	4	1	1
$20,000–$29,999	2	1	0	0	1	0
Other Income[b]						
Less than $10,000	29	85	98	26	87	98
$10,000–$19,999	40	9	1	38	5	1
$20,000–$29,999	17	5	0	21	6	0
$30,000–$39,999	9	1	0	10	1	0
$40,000–$49,999	5	1	0	3	0	0
$50,000 or more	1	0	0	2	1	0
Total Family Income						
Less than $10,000	4	4	0	4	2	0
$10,000–$19,999	11	14	8	7	16	8
$20,000–$29,999	20	18	14	12	16	14
$30,000–$39,999	17	19	16	16	20	17
$40,000–$49,999	8	13	16	7	15	16
$50,000 or more	40	32	46	53	31	45

Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.

[a]Asset income includes interest from savings accounts, money market funds, securities, and bonds; stock dividends received and reinvested; net rental income, mortgage interest, and royalties or other investment income.

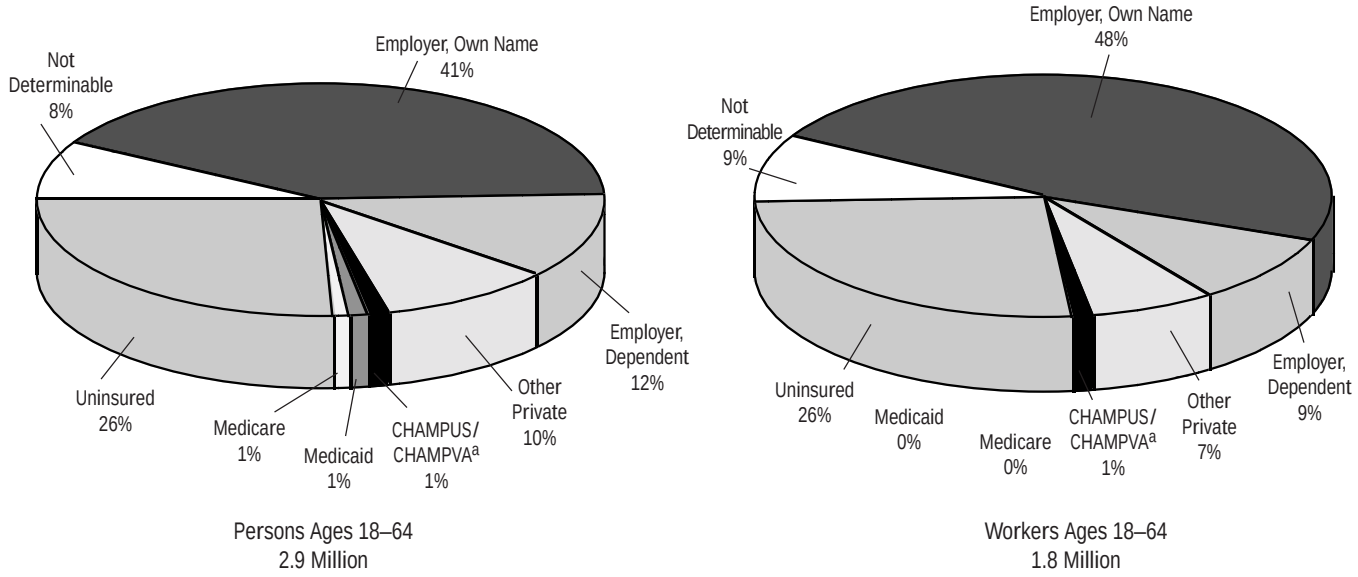
[b]Other income includes Social Security, railroad retirement, unemployment compensation, supplemental employee benefits, veterans' compensation, workers' compensation, employer or union temporary sickness payments, disability insurance, child support, alimony, private or public pension income, annuity income, and other cash income not included elsewhere. It does not include means-tested cash transfer payments.

Job-Lock and Benefits

Job-lock has been a primary motivator behind proposals to increase health insurance portability. Researchers, policymakers, and the general public give varying estimates of the extensiveness of job-lock. To determine its extent, some researchers have examined the effects of health insurance on job mobility for individuals in the labor force and have conducted both public opinion surveys and in-depth research in this area. Another way to glean information on job-lock is to examine the effects of health insurance availability on overall labor force participation. For example, does

Chart 3

Sources of Coverage After Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage
Persons and Workers Ages 18–64 Whose COBRA Spell Ended During Survey



Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.
[a]Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration.

access to either COBRA coverage or retiree health benefits encourage workers to leave the labor force earlier than workers without access to such coverage? This section gives an overview of these estimates.

Health Insurance and Job-Lock

Several studies have been conducted regarding job mobility and health insurance. In general, the findings are mixed, and do not uniformly support or refute the existence of job-lock. Studies that do support the theory of job-lock show wide variation in the magnitude of its effect, related to demographic and employment-based characteristics.

Mitchell (1982) published one of the first empirical studies on job mobility and employee benefits. Using data from the 1973 and 1977 Quality of Employment Survey, she analyzed job changes and employee benefits due to voluntary departures and involuntary layoffs and discharges. The study found that loss of a pension promise was a particularly strong deterrent to quitting for males. Males with pensions were 10 percent less likely to quit a job than those without pensions. Health insurance was found to have a small, insignificant effect on a worker's decision to quit. Specifically, health insurance reduced the probability of quitting by approximately 4 percentage points for males. However, in more elaborate followup research, which incorporated the cost of job change into the model, health insurance was found to increase the size of the cost of changing jobs; therefore, it affected turnover, but was only about one-half of the pension effect (Mitchell, 1983).

Cooper and Monheit (1993) also considered how workers' job mobility is affected by health insurance. They used data on wage and salary workers ages 25–54 from the 1987 National Medical Expenditure Survey to determine how potential wage offers, health insurance offers, and the costs of changing jobs affected job mobility. Overall, they found strong evidence in support of job-lock. Specifically, among workers who were likely to lose coverage on job change, job mobility was reduced by 24.8 percent for married males, 34.7 percent for married females, 24.8 percent for single males, and 38.8 percent for single females, when compared with workers whose insurance status was expected to stay the same.

Madrian (1994) also found strong evidence of job-lock. Also using data from the 1987 National Medical Expenditure Survey, Madrian found that job-lock reduces the voluntary turnover rate of married male workers ages 20–55 between 26 percent and 31 percent. When controlling for expected medical costs, the study found an even higher degree of job-lock. When using family size to predict medical costs, mobility rates were

reduced between 33 percent and 37 percent for those with employment-based health insurance. Furthermore, mobility rates were reduced by 67 percent for married males with employment-based health insurance and a pregnant wife.

Gruber and Madrian (1994) took a different approach when examining the effect of state continuation-of-coverage mandates on job mobility. Using data from the 1984–1987 SIPP panels, they found that state continuation-of-coverage mandates were associated with a significant increase in job mobility among males ages 20–54. Specifically, the study suggests that one year of access to continuation of coverage is associated with a 10 percent increase in mobility among workers with employment-based health insurance.

In contrast to the above studies, Holtz-Eakin (1994) found little evidence that employment-based health insurance affects job mobility. Using data from the 1984 wave of the Panel Study of Income Dynamics, he found a correlation between job mobility and health insurance for full-time workers ages 25–55. However, when total compensation was included in the analysis, health insurance had virtually no effect on job mobility. Specifically, the study found that mobility rates for married males were reduced 1.6 percentage points and mobility rates for single females were reduced 1.1 percentage points, although neither estimate was statistically significant. For married females and single males, no effect was found. These results may be confounded by the fact that Holtz-Eakin examined job mobility over the three-year period 1984–1987, but only had health insurance data for the year 1984. The study also tested for job-lock using data from Germany and reached similar conclusions.

In order to quantify the effects of job mobility on the economy, it is necessary to understand how potential wage gains are affected by job-lock. Monheit and Cooper (1994) determine that job-lock affects approximately 1.6 percent of workers ages 25–54. Furthermore, it results in a loss of productivity of less than 1 percent of their wages. While they do find that job-lock affects productivity and job mobility, the productivity effects are relatively small because very few workers are affected by job-lock.

Buchmueller and Valletta (1996) attribute the foregoing conflicting results to models that did not take into account the effects of pension plan participation, job tenure, and spousal job change. After taking these effects into account, the study found strong evidence of job-lock among single and married females and weak evidence of job-lock among single and sole-earner married males.

Retiree Health Insurance and Early Retirement

Until recently, research has not examined the relationship between retiree health insurance and the decision to retire. This is an area of increasing significance because of rising health care costs for retirees, Medicare's uncertain future, and increased life expectancy. In general, results from the studies suggest that individual retirement decisions are strongly responsive to the availability of retiree health insurance, with additional implications for the job mobility of workers seeking to remain in the labor force.

Hurd and McGarry (1993) examined the retirement intentions of current workers, as opposed to the actual retirement patterns of individuals who had already retired. Specifically, this study examined the effect of the availability of retiree health insurance on the probability that a full-time worker would work full time past age 62. It used data from the 1992 Health and Retirement Study. Workers in the survey were asked, on a scale of 0 to 100, what the chances are that they would work full-time after they reached ages 62 and 65. Few studies of retirement behavior have used data on the *prospects* for work change. Most studies focus on retired workers and how they responded, retrospectively, to various factors affecting the retirement decision. The study found that the availability of retiree health insurance that was at least partially employer funded reduces the probability that a worker would work full-

Typically, health insurance purchased directly from an insurance company is more expensive than that purchased through an employer, especially for older individuals who are not eligible for Medicare.

time after age 62 by between 18 percent and 24 percent.

Karoly and Rogowski (1994) analyzed the effect of the availability of postretirement health insurance on early retirement behavior. Limiting the study to men, they found that the availability of this insurance would increase the probability of early retirement by 50 percent, or approximately 9 percentage points. They also found evidence that the presence of health insurance coverage in addition to employer-provided insurance increased the likelihood of early retirement. This source of insurance was usually through the wife's employer. However, this study suffers from a number of shortcomings that may have affected the results.[13]

Madrian (1994) found that individuals with retiree health insurance retired between 5 and 16 months earlier than those without retiree health insurance, with most of the results occurring at about one year. This study also found that the probability of retiring before age 65 was between 7 and 15 percentage points higher for individuals with retiree health insurance. This study also suffers from a number of shortcomings. An attempt is made to control for participation in a pension plan, but the results are inconclusive. While Madrian can observe the actual retirement behavior of a group of retirees, some of the retirees in the sample have been retired for as many as 15 years and must remember their health insurance and pension status at the time of retirement. As a result, the study must infer that individuals with private health insurance through a former employer are in fact covered by retiree health insurance. In addition, the data include pension and Social Security wealth, but it is unclear how these data were used in the analysis.

Gustman and Steinmeier (1994) used a life-cycle model of retirement that incorporates the value of retiree health benefits and also includes information on pension accruals. They found that employer-provided health benefits lowered male retirement age by approximately 1.3 months. As the authors point out, their life-cycle model approach may tend to underestimate the effect of retiree health insurance on labor force withdrawal.

Finally, Gruber and Madrian (1995) took a different approach than that of the previous studies. They examined the effect of state and federal continuation-of-coverage mandates on the decision to retire.[14] These mandates allow individuals to continue purchasing health insurance through a previous employer at group rates. While this health insurance coverage is technically not considered retiree health insurance, it does benefit individuals by allowing them to purchase health insurance at a group rate. Typically, health insurance purchased directly from an insurance company is more expensive than that purchased through an employer, especially for older individuals who are not eligible for Medicare. The implicit group rate subsidy may allow individuals to continue health insurance coverage after retiring, in effect inducing early retirement, especially if they do not qualify for Medicare benefits. This study found that the probability of retiring increases 32 percent (2.2 percentage points) for each additional year of continuation of

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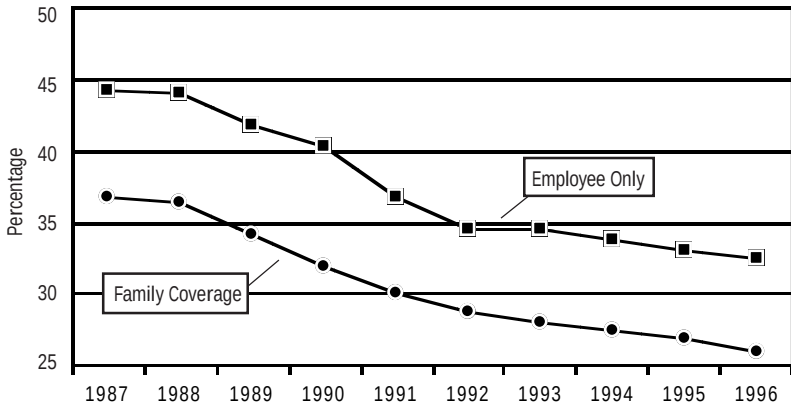
[13] *First, the study does not use actual reported data on retiree health insurance. Instead, the availability of retiree health insurance is imputed based on firm size, industry, and region. As a result, the estimated retirement effects of retiree health insurance may be overestimated because firm size and industry may be highly correlated with retirement decisions for reasons other than health insurance, such as pension plan provisions. Second, the results may be overstated because the study does not take into account accumulated pension or Social Security wealth. DB plans may contain strong economic incentives to retire early. Since this study does not capture the influence of these types of plans, the effect of retiree health insurance may actually represent the combined effect of retiree health benefits and pension benefits. While the study does attempt to control for pension eligibility, the ability to capture the effects of pension eligibility on early retirement is limited by the fact that pension eligibility is missing for 26 percent of the sample. Third, the study is not able to control for union status. Union members are typically eligible for additional retirement benefits at age 60 or age 62 to supplement their income until they reach full Social Security eligibility.*

[14] *Because COBRA does not apply to employers with fewer than 20 workers, a number of states have enacted COBRA-type continuation-of-coverage mandates that only apply to the small group market.*

Chart 4

Percentage of Persons with Employment-Based Health Insurance in Own Name Whose Employer Fully Financed Health Insurance, 1987–1996



Source: Employee Benefit Research Institute estimates from the March 1988–1997 Current Population Surveys.

coverage.[15] However, the study may overestimate the effects of continuation of coverage on retirement, if individuals are using continuation-of-coverage benefits as a bridge to future employment, as opposed to a bridge to Medicare eligibility. In fact, the study found that job changers account for approximately 16 percent of the retirement effect.

Conclusions

HIPAA included provisions that directly affected COBRA by clarifying eligibility criteria for newborns and adopted children and individuals with disabilities. These were minor changes to COBRA. More important, however, is the possibility that HIPAA may indirectly result in more individuals electing COBRA coverage, and may result in individuals keeping COBRA coverage for longer periods. HIPAA allows individuals who keep their coverage in effect to avoid preexisting condition waiting periods, and guarantees issue in the individual market after COBRA benefits have been exhausted. These HIPAA provisions, combined with any attempt to expand COBRA coverage further, either through subsidies or by allowing workers to choose from plans with lower premiums, will likely result in increased employer health care costs. Survey data indicate that the primary issue concerning COBRA is its impact on claims experience and administrative costs for active employees, employers, and COBRA beneficiaries. If the cost issues are not addressed with future COBRA expansions, employers may consider various alternatives to reduce, shift, or eliminate the impact of this increased cost.

One alternative is for employers to continue requiring active employees to share in the increased costs through higher employee contributions. Since at least 1987, employers have been increasingly shifting the cost of health insurance coverage onto workers. In 1987, 44.2 percent of workers with employee-only coverage had that coverage fully financed by their employer, compared with 32.5 percent in 1996 (chart 4). In addition, 36.7 percent of workers with family coverage had that coverage fully financed by their employer in 1987, compared with 25.9 percent in 1996. As the employee share of health insurance premiums increases, active employees increasingly pay part of the cost of adverse claims experience under COBRA (above the 102 percent of premium/cost allowed) because former employees and their families under COBRA are not paying the true cost of the coverage they are receiving. Over time, the premium charged COBRA beneficiaries would also gradually increase because it is based on the employer's premium (or cost) for coverage of active workers. As the charge for COBRA coverage increases, fewer COBRA beneficiaries may be able to pay for continued coverage.

A second alternative is to reduce or eliminate health care benefits for active employees and/or future retirees and their families, thereby reducing or eliminating the COBRA continuation coverage. This might be a particularly attractive option for small employers who are already experiencing high health insurance premiums. In addition, small employers are not as likely as large employers to absorb cost increases. The reduction

[15] *The authors limited their sample to males ages 55–64. Individuals were defined as being retired if they reported being retired at the time of the survey (March) and they had worked at least one week during the previous year. Almost 7 percent of the sample was defined as retired.*

in coverage shifts a greater share of the cost to employees, but elimination of coverage obviously reduces access.

A third alternative is to reduce the size of the work force eligible for health insurance benefits. Employers could accomplish this by substituting part-time workers for full-time workers, or by increasing the hours worked by full-time workers. Fronstin and Snider (1996/97) found that the increased use of part-time workers as a percentage of the labor force accounted for 7 percent of the decline in employment-based health insurance between 1988 and 1993. Furthermore, Cutler and Madrian (1997) found that hours of work increased for insured workers by 0.06–0.10 hours per week, compared with uninsured workers. The study also found that hours of work increased more rapidly in industries with relatively high health insurance costs.

Finally, where possible, the employer may pass additional costs along to workers or consumers. Workers could be affected if wage increases are not as large as they would have been had COBRA costs not been an issue. Consumers would be affected if employers raised product prices, creating additional inflationary pressure in the economy.

The survey data and the alternatives available to employers to deal with increased medical plan costs suggest that some changes to COBRA may be necessary. If current coverage levels continue to be required, an increase in the percentage of premiums allowed to be charged to COBRA beneficiaries may be in order to accommodate the higher level of claims costs associated with COBRA beneficiaries. The Clinton administration has recognized this idea in its FY 1999 budget proposal. One provision in the proposal would define another COBRA qualifying event as occurring for current retirees when an employer drops retiree health benefits. This provision would allow retirees to elect COBRA coverage, but employers would be allowed to charge 120 percent–125 percent of the premium. Any such increase should consider both the current effect COBRA claims are having on employers and COBRA beneficiaries' ability to continue the coverage if the premium becomes too high.

Another alternative would be to reduce the length of time COBRA coverage is required to be offered. A shortened rather than lengthened COBRA coverage continuation period could help reduce employers' administrative costs. While those most likely to be affected are families of former employees, the survey data indicate that the majority of COBRA beneficiaries would not be adversely impacted. The longer-term loss of coverage problem could be dealt with as part of the larger overall issue of health care access, costs, and quality. However, with COBRA and HIPAA generating a relatively large-scale debate over legislation that does very little to affect coverage levels, even larger scale reforms concerning health care access, costs, and quality will likely be that much more difficult to accomplish.

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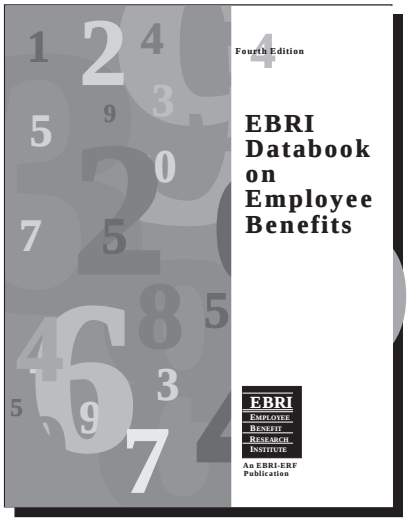

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