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COBRA: A Closer Look at Who Enrolls and the Case for Subsidies

By Jake Spiegel and Paul Fronstin, Ph.D., Employee Benefit Research Institute

AT A GLANCE

- The recently passed Coronavirus Aid, Relief, and Economic Security (CARES) Act and the proposed Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act have provisions that make it more appealing for unemployed workers to claim Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) benefits, which can be a benefit to the newly unemployed and their families to the extent it helps them maintain the health insurance coverage they received through their erstwhile employer.
- However, there exists a significant potential for adverse selection; since COBRA benefits are relatively expensive (beneficiaries must pay the full cost of the employee and employer contributions toward health insurance), and since those eligible normally have 60 days to formally elect benefits, perhaps only those who stand to face large medical expenditures will choose to take up COBRA benefits.
- However, the extent to which COBRA beneficiaries use more health care services than their full-time-employed counterparts has not been adequately examined to this point.
- EBRI's analysis examines the extent to which people covered by COBRA are higher health care spenders than full-time employees and their dependents. Our analysis indicates that COBRA beneficiaries are systematically different from those who receive health insurance through a full-time employee. The key findings are:
    - The average COBRA beneficiary is older and less healthy than their counterpart. For example, among those with individual coverage, COBRA beneficiaries are on average 50 years old, while full-time employees are 42.6 years old on average.
    - COBRA beneficiaries are more likely than those receiving coverage through a full-time employee to have certain health conditions, such as COPD, diabetes, cancer, high blood pressure, high cholesterol, mental health disorders, and musculoskeletal disorders, and they are more likely to have spent more days in a hospital than those receiving coverage through a full-time employee.
    - The average COBRA beneficiary uses more health care services and spends significantly more than the average person covered by insurance via a full-time employee. In 2018, among those with employee-only coverage, full-time employees used an average of $6,724 in health care services. COBRA beneficiaries used an average of $18,752, a nearly 300 percent difference.
- Subsidies can help reduce adverse selection against COBRA plans. By making COBRA plans more attractive relative to alternatives, healthier people will choose to enroll in COBRA, which can help improve an employer's risk pool. However, the ratio of spending by COBRA beneficiaries to spending by those covered by insurance via a full-time worker has decreased since the implementation of the Patient Protection and Affordable Care Act (ACA) health insurance exchanges, suggesting that the ACA exchanges have slightly mitigated adverse selection.
- With the availability of subsidized health insurance for people with income under 400 percent of the federal poverty level for those purchasing health coverage in ACA exchanges, it is debatable as to whether subsidies for COBRA coverage are necessary in a post-ACA world.

Jake Spiegel is a Research Associate at the Employee Benefit Research Institute (EBRI). Paul Fronstin is Director of the Health Research and Education Program at EBRI. This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Table of Contents

Figures

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Introduction and Background on COBRA

Employment-based health benefits are the most common form of health insurance in the United States. In 2018, 178.4 million individuals, or 55.1 percent of the population, had employment-based health benefits.[1] In contrast, Medicare and Medicaid each only covered 58 million people. It is likely that the number of people covered by employment-based health benefits dropped significantly when the pandemic related to the coronavirus caused the U.S. economy to come to a near-screeching halt.[2] Between mid-March and late May, there were over 40 million new claims for unemployment. Many businesses that have been able to remain open have cut worker hours. Along with their jobs, many workers have likely lost employment-based health benefits. Thus, we are likely to see some combination of higher Patient Protection and Affordable Care Act (ACA) marketplace enrollment and Medicaid enrollment as well as an increase in the uninsured.

We are also likely to see higher COBRA coverage enrollment. COBRA is the acronym for the Consolidated Omnibus Budget Reconciliation Act, a federal law that was signed into law in 1985. The legislation allows workers to continue participating in their employment-based health insurance coverage after separating from their employer. The policy goals behind COBRA are to allow workers to continue their health insurance and remain off public insurance programs and to prevent people from becoming uninsured. It also allows providers to be reimbursed at private pay rates instead of Medicaid rates, which are lower than private pay rates, and allows providers to avoid the cost of uncompensated health care associated with uninsured individuals. The Coronavirus Aid, Relief, and Economic Security Act (also known as the CARES Act), passed in late March 2020 to address the adverse economic effects from the pandemic related to the coronavirus, extended the time period for COBRA elections. Such a change has major implications for workers, employers, and insurers, which will be discussed in more detail below.

While COBRA allows workers to continue their health insurance, it does not require employers to pay for it. COBRA beneficiaries pay both their share and their employer's share of the premium. Only a small share of people take COBRA coverage because they consider it very expensive, especially when it generally coincides with a loss of income. Because of the high cost of COBRA, those who do take it tend to be disproportionately less healthy than the average person with employment-based coverage, a phenomenon known as adverse selection. During the Great Recession, Congress passed the American Recovery and Reinvestment Act of 2009 (ARRA), which included a provision for the federal government to pay 65 percent of the premium for individuals who were covered under COBRA and who incurred an involuntary job loss between Sept. 1, 2008, and Dec. 31, 2009. The subsidy was made available for up to nine months and was extended by Congress three times. The purpose of the subsidy was to ease the financial burden of the unemployed. There are calls today to reinstate COBRA subsidies. On May 15, 2020, the U.S. House of Representatives passed the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, which would provide a 100 percent federal subsidy of COBRA premiums between March 1, 2020, and Jan. 31, 2021, for individuals and their dependents who have lost employment-based health benefits.

Whether it is necessary to provide subsidies in today's economic climate is a matter of debate. When COBRA subsidies were last provided in 2010, the ACA marketplace did not yet exist. Subsidies for ACA marketplace coverage for those individuals with income below 400 percent of the federal poverty level were a few years away from being available. And cost-sharing reductions or subsidies that help cover out-of-pocket expenses such as deductibles, copayments, and coinsurance for individuals with income below 250 percent of the federal poverty level were also a few years away from being available.

The purpose of this paper is to examine the issue of adverse selection among COBRA beneficiaries in more detail using more recent data. We then discuss how COBRA subsidies may mitigate adverse selection. The next section of the paper provides more detailed background information on COBRA.

Background on COBRA

The continuation-of-coverage provision included in COBRA requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct. COBRA ensures that workers who lose their health coverage when they lose their job or become ineligible for coverage because they move from full-time to part-time work can continue it for 18 months. In cases involving the employee's death, divorce, legal separation, Medicare entitlement, or loss of a child's dependency status, either initially or at any time during the continuation of coverage period, the qualified beneficiary must be allowed to elect COBRA coverage for up to a maximum of 36 months from the first qualifying event.

The law does not require employers to continue paying for COBRA; the entire premium for health coverage must be paid by the individuals electing COBRA coverage when plan sponsors require them to do so. Qualified beneficiaries pay not only the full premium, but they can also be charged an additional 2 percent administrative fee. In the case of individuals considered disabled for Social Security purposes, 150 percent of the employer's cost may be charged for the 19th month through the balance of the COBRA period for that individual and other family members who also qualify for this continuation of coverage. Those who utilize their right to COBRA coverage often find it to be surprisingly unaffordable, especially during periods of unemployment that are often combined with loss of income and a movement from paying premiums on a pre-tax basis to paying them on an after-tax basis. Health savings accounts (HSAs) can be used to pay COBRA premiums on a pre-tax basis.

Employees and their dependents covered by an employment-based group health plan (provided by a private-sector employer with at least 20 employees) on the day before a qualifying event are eligible for COBRA. Employees covered by church plans are not necessarily covered by COBRA, since their employer is not required to provide continuation of coverage. Employees of states and any political subdivision, agency, or instrumentality of such states are protected by COBRA, and federal employees (and their dependents) are covered by provisions similar to those of COBRA.

Notification Requirements

The employer must notify the employee and his or her spouse of the right to continued coverage under COBRA when they are first covered under the plan and at the time of certain COBRA-qualifying events. An employer whose health plan is not self-administered normally must notify the third-party administrator within 30 days of an employee's termination of employment, reduction in hours, death, Medicare entitlement for retired employees and their families, or the employer's bankruptcy.[3] The third-party administrator has 14 days from the time it is notified of a qualifying event to notify the beneficiaries of their COBRA rights. Employers that self-administer their own group health plans have 44 days to notify beneficiaries. Multi-employer plans have longer notification periods.

Qualified beneficiaries then have 60 days to elect coverage after being notified by the plan administrator of the right to COBRA coverage. Prior to the passage of the CARES Act, premium payments for periods preceding the election could not be required before 45 days after the election. This allowed qualified beneficiaries great flexibility in determining whether to enroll in COBRA. If all permissible time periods reached their maximum length, a qualified beneficiary would have had up to 149 days to decide to accept COBRA coverage after the qualifying event. If the qualified beneficiary chose to not pay at the time due, nothing was lost except the coverage. Therefore, qualified beneficiaries often took a wait-and-see approach to determine whether paying for coverage was in his or her best interest; there was no downside to initially electing COBRA coverage. Unless future health coverage was certain, it would be in the best interest of the qualified beneficiaries to delay the election of COBRA coverage and also to delay the actual payment of premiums as long as the law allowed.

The CARES Act's Impact on COBRA

Prior to passage of the CARES Act, qualified beneficiaries had 60 days to elect coverage after being notified by the plan administrator of the right to COBRA coverage. The CARES Act gives qualified beneficiaries additional time to elect

COBRA coverage. Specifically, qualified individuals have until 60 days after the end of the national emergency to elect COBRA coverage under the CARES Act.

In order to understand the additional time period, it is helpful to define one key date: the end of the COVID-19 national emergency. National emergencies can be declared using the National Emergencies Act of 1976 and/or the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988. Both acts were used to declare a national emergency on March 13, 2020. As of this writing, the end date of the national emergency has not been announced. We are currently still in the national emergency.

For purposes of explaining the additional COBRA election period, let's assume that the national emergency ended on June 29, 2020, which is one of the examples used in the DOL/Treasury final rule released on April 28, 2020.[4] Qualified beneficiaries would then have until Aug. 28, 2020, to elect COBRA coverage. COBRA coverage is then retroactive to the date that a beneficiary would have lost coverage. So, if coverage were lost on April 1, 2020, potential COBRA beneficiaries would have the better part of 5 months to elect coverage, and the coverage would be retroactive to April 1. The COBRA beneficiary would have another 45 days after Aug. 28, 2020, to pay any past premiums.

Adverse Selection of COBRA Enrollees

Workers who enroll in COBRA may differ systematically from workers who choose to not take up coverage. Since workers who separate from their jobs do not immediately have to declare their intention to take up COBRA benefits, there exists a significant potential for adverse selection. Workers might wait until they have incurred a significant medical expenditure before retroactively taking up COBRA benefits. They may wait further to pay any COBRA premiums in order to maximize the amount of time they have to elect COBRA coverage. Hence, those who incur medical expenses that would cost more than COBRA premiums are most likely to elect COBRA coverage, and those who expect to incur significant medical expenses might choose to enroll in COBRA coverage, whereas their healthier counterparts might instead choose to go without insurance or take up less generous coverage in the individual marketplace. Graetz et al. (2012) found that COBRA enrollees were more likely than non-enrollees to be sicker and older and to have higher cost sharing and higher incomes.

Employers, especially those who are self-insured, consider COBRA a costly mandate. Premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered. Self-insured employers bear the brunt of adverse selection to the degree COBRA beneficiaries use more health care services than the average worker or dependent with coverage through the workplace. The extension of the COBRA enrollment date as a result of the CARES Act has the potential to exacerbate the issue of adverse selection.

COBRA Take-Up

Relatively few workers choose to take up COBRA benefits. The U.S. Treasury Department conducted a study of COBRA claimants in New Jersey and found that only 15 percent of unemployment insurance beneficiaries took up COBRA benefits.[5] One reason that few choose to take up COBRA benefits is that enrolling and maintaining benefits can be expensive. Many employers subsidize the health benefits they provide for their employees. According to the Kaiser Family Foundation, workers paid on average 18 percent of their health insurance plan's premiums. However, in general, COBRA beneficiaries must pay the full price of their health insurance coverage. For employers with generous coverage, the total premiums borne by COBRA beneficiaries can be substantial. In the 2019 Employer Health Benefits Survey, the Kaiser Family Foundation estimated that the average annual premium for single-coverage employer-sponsored health insurance was $7,188.[6] For family coverage, the average annual premium was $20,576. In the face of the potentially steep premiums paid by COBRA enrollees, the U.S. Treasury Department study unsurprisingly concluded that COBRA tended to benefit middle- and upper-middle-income households.[7]

Health Savings Accounts and COBRA

Health savings accounts (HSAs) are tax-exempt trust or custodial accounts that are funded with contributions that an individual can use to pay for health care expenses. Individuals can contribute to an HSA only if they are enrolled in an

HSA-eligible health plan. HSAs benefit from a triple tax advantage: Employee contributions to the account are deductible from taxable income, any interest or other capital earnings on assets in the account build up tax free, and distributions for qualified medical expenses from the HSA are excluded from taxable income to the employee. In 2020, contributions are limited to $3,550 for people with individual coverage and $7,100 for those with family coverage.

COBRA premiums can be paid from HSAs for individuals receiving unemployment benefits. This is significant because over 42 million people filed unemployment claims between March 21 and June 4, 2020. Those individuals with an HSA are able to use the money in their account to pay COBRA premiums. Also, because the IRS moved the due date for filing federal income tax returns to July 15, 2020, due to the coronavirus, HSA contributions may be made until then that count against the 2019 contribution limit. Those individuals who did not contribute the maximum to their HSA in 2019 are in a position to take advantage of the extended filing period in order to pay COBRA premiums using HSA contributions.[8] The use of HSAs to pay COBRA premiums makes those premiums more affordable at a time when people might otherwise find paying such premiums challenging.

Data

COBRA benefits are unique in that potential beneficiaries do not have to elect coverage immediately after separating from an employer. This presents a unique adverse selection mechanism. Potentially, only those who have high medical expenses (or those who want to cover someone who does, such as a spouse or dependent) will elect coverage. However, the extent to which people covered by COBRA are higher health care spenders than those who receive coverage through a full-time employee has to this point been recently unexamined. To answer this question, EBRI makes use of the IBM Health Analytics Marketscan® Commercial Claims and Encounters Databases (copyright © IBM Health Analytics, all rights reserved). We used 2013–2018 data on health insurance eligibility and health care claims. The 2018 data was based on nearly 800,000 active full-time workers, partners, and dependents and 46,000 COBRA beneficiaries. We included only those who were under 65 years old who were continuously enrolled in their health plan the entire calendar year.

Since we hypothesized that health status would likely be correlated with COBRA enrollment, we included three sets of such measures. First, we derived the Charlson Comorbidity Index (Charlson et al. 1987) (Deyo, Cherkin, and Ciol 1992) (Quan et al. 2005), which is widely used in the extant literature as a gauge of general health status. Medical conditions such as diabetes, cancer, and heart disease are included. Overall, the CCI currently consists of 17 conditions, and some are combined in our analysis.[9]

Variables

A robust vector of demographic, insurance plan, and health status independent variables was created by year. Gender, age, geographic region, household size, and health plan type were captured. A dichotomous variable for having a covered spouse or child was also constructed. We also examined industry of employment for the policyholder.

Second, we generated a more general vector of other chronic conditions and selected indicator variables for the presence of health conditions that were not specifically picked up by the CCI using the Clinical Classification System (CCS). An individual was considered to have a given condition if he/she had one or more inpatient, or two or more outpatient (on different dates) claims with an associated candidate International Classification of Diseases (ICD-10) code. Conditions included high blood pressure, high cholesterol, schizophrenia/bipolar disorder and other mental health conditions, rheumatoid arthritis and other related diseases, multiple sclerosis, ulcerative colitis, respiratory disease, asthma/chronic obstructive pulmonary disease (COPD), and other conditions and diseases. In addition, an indicator for childbirth was created based also on diagnosis codes on mothers' claims for deliveries.

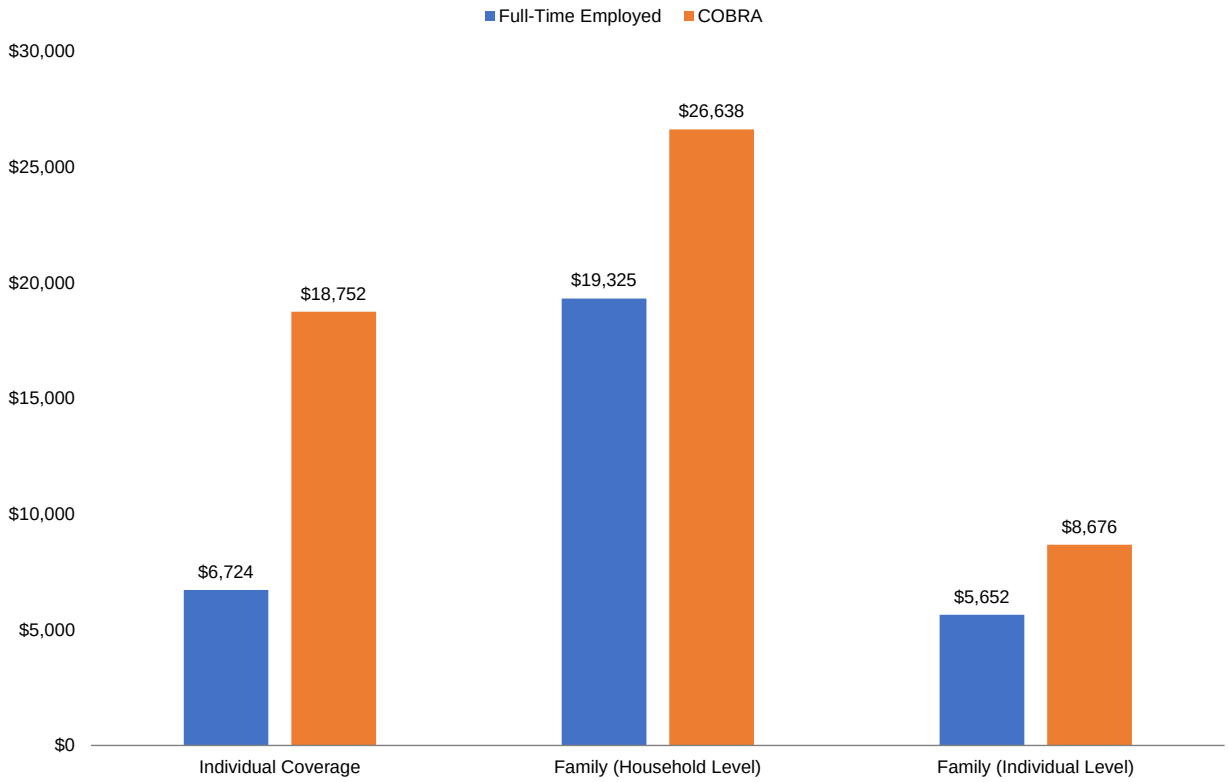
Third, measures of use of health services and costs were also constructed. Specifically, the numbers of inpatient hospital days, emergency department visits, primary care physician visits, specialist physician visits, and prescription

drug fills were examined. We also looked at more detailed outpatient services, such as lab tests, various radiology exams, and other types of office visits.

Summary of Findings

Our analysis finds that COBRA enrollees spend more on health care than full-time employees still receiving health insurance benefits through their employer. In 2018, the year for which we have the most recent data, the average person with individual coverage through COBRA spent $18,752, compared with the average person with individual coverage through work who spent $6,724, shown below in Figure 1. Similar disparities exist for family coverage, as the average household with COBRA benefits spent $26,638, compared with their full-time employed counterparts, who spent an average of $19,325, also shown below.

Figure 1
Overall Spending on Health Care Services, by Coverage Status, 2018

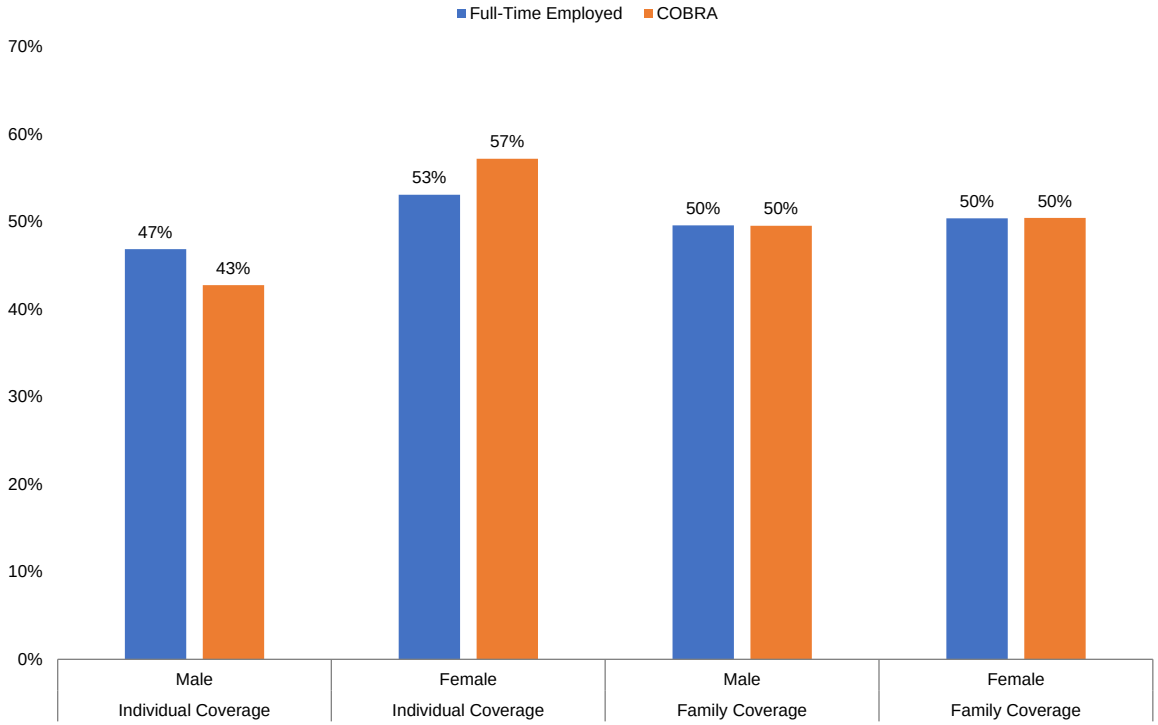


Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

To better understand why COBRA beneficiaries spend more, we examine the demographic differences between those covered by a COBRA policy and those covered by a policy via a full-time employed worker. For those with individual coverage, we immediately notice several important differences. First, COBRA enrollees are disproportionately female, seen below in Figure 2. About 53 percent of those with individual coverage through a full-time employee are female, compared with 57 percent of individual COBRA enrollees, though no significant difference exists for those with family coverage. We also find that the average COBRA enrollee with individual coverage is about 7.5 years older than their counterpart with coverage through full-time employment, seen below in Figure 3. Further, those covered by COBRA are disproportionately in the 55–64 age cohort compared with those covered through a full-time employee (Appendix Figure 1). Both gender and age differences between people with individual coverage through COBRA and full-time employment are statistically significant at a 1 percent level. There also exist some significant demographic differences between those with family coverage through COBRA and family coverage through a full-time worker. The average age of a person with family coverage through a full-time employee is 30.5, compared with 37.3 for COBRA coverage (Figure

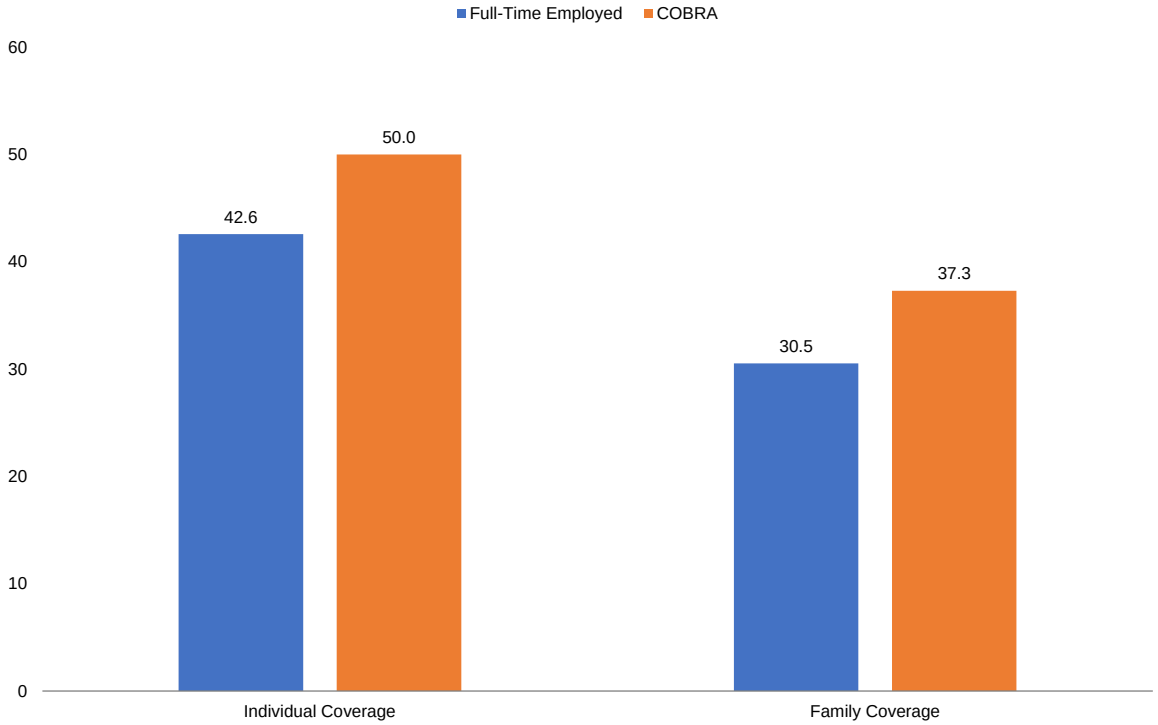
1), a similar gap to what is observed for people with individual coverage.[10] Like those with individual coverage, those with family coverage under COBRA are much more likely to fall into the oldest age demographic than those with coverage through a full-time employee (Appendix Figure 2).

Figure 2
Gender Differences by Coverage Status, 2018



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 3
Average Age, by Coverage Status, 2018



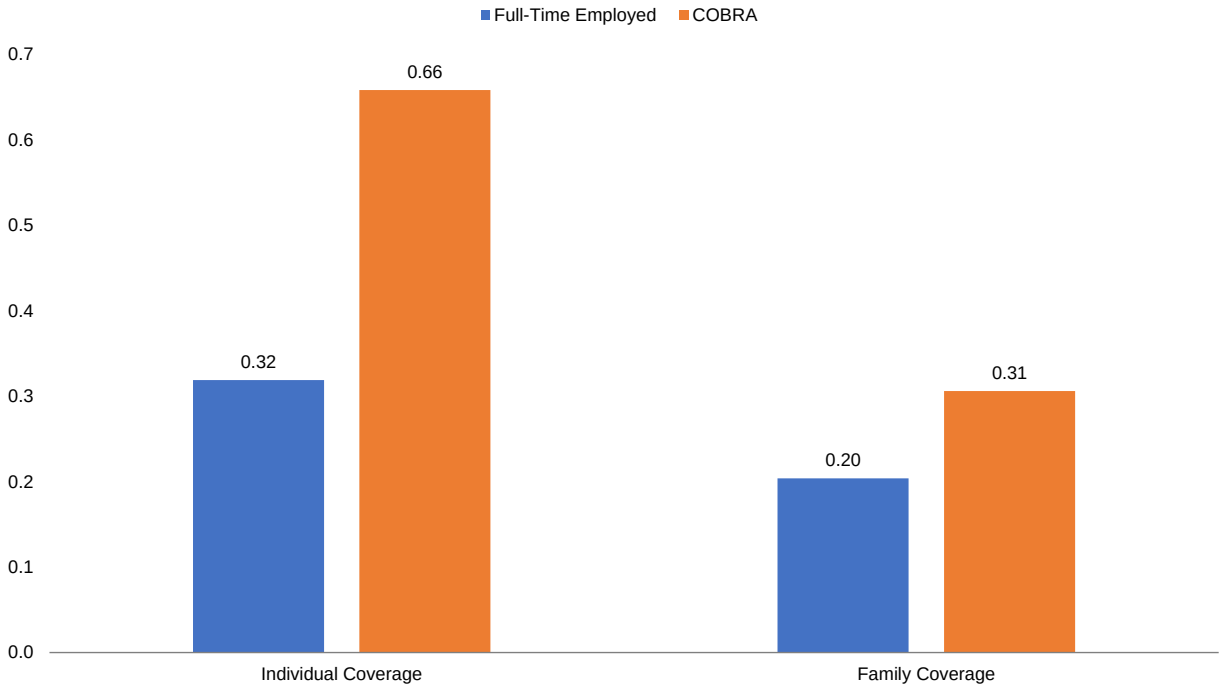
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

The expected medical expenditures of family members appear to play a role in the decision to take up COBRA benefits for family coverage. In particular, a partner with significant medical expenditures might induce a worker recently separated from a job to enroll in COBRA. We find that 23 percent of those who receive coverage through a full-time employer are a spouse of the policyholder, whereas 28 percent of those who receive coverage through COBRA are a spouse of the policyholder. This difference is statistically significant at a 1 percent level and shows that families with COBRA coverage might be more motivated to elect COBRA benefits if a partner expects large medical expenses. On a related note, COBRA households less frequently contain a dependent under the age of 18: 23 percent compared with 31 percent of full-time-employee households. This may indicate that COBRA enrollees are primarily driven by medical expenses incurred by themselves or their partners and not their dependents. But it also reflects the fact that COBRA households tend to be older and will be less likely to have children under 18.

COBRA Claimants Tend to Be Less Healthy…

We find that COBRA claimants tend to be less healthy than people with coverage through a full-time employee, and these differences are persistent across individual and family coverage. For this analysis, we use the CCI, an index comprised of medical conditions that is often used to predict one-year mortality rates among individuals as a proxy for health. Individuals with coverage through a full-time employee have an average CCI of 0.32, compared with individuals with COBRA coverage who have an average CCI of 0.66 — a large difference that is statistically significant at a 1 percent level, shown below in Figure 4. Specifically, those who receive coverage through COBRA more frequently have chronic conditions that are expensive to treat, such as congestive heart failure, cerebrovascular disease, chronic obstructive pulmonary disease, diabetes, and renal disease. This suggests that people who take up COBRA benefits might do so specifically because they anticipate the large expenses that often accompany these chronic conditions. The full CCI conditions, as well as selected CCS conditions, are reported in Appendix Figure 3 for individual coverage and Appendix Figure 4 for family coverage.

Figure 4
Charlson Comorbidity Index (CCI*), by Coverage Status



* CCI is an index comprised of the following conditions: acute myocardial infarction, congestive heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease (COPD), rheumatoid disease, peptic ulcer, mild liver disease, diabetes, hemiplegia or paraplegia, renal disease, cancer, moderate/severe liver disease, and AIDS.

Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 5
Presence of Select Health Conditions, by Source of Coverage

	Individual Coverage			Family Coverage		
Variable	**Full-Time Employee**	**COBRA**		**Full-Time Employee**	**COBRA**	
High Cholesterol	14%	23%	**	9%	15%	**
High Blood Pressure	15%	21%	**	8%	11%	**
Mental Health Disorders	7%	14%	**	6%	9%	**
Spine and Back Disorders	7%	13%	**	6%	8%	**
Diabetes	8%	11%	**	4%	6%	**
Respiratory Disease or Infection	8%	11%	**	10%	11%	
Connective Tissue Disease	5%	10%	**	4%	7%	**
Non-Traumatic Joint Disorders	5%	9%	**	4%	6%	**
Chronic Obstructive Pulmonary Disease (COPD)	5%	8%	**	5%	6%	
Cancer	2%	6%	**	2%	3%	**
Nervous System Disorders	2%	5%	**	2%	3%	**
Thyroid Disorders	3%	4%	**	2%	3%	*

**Indicates statistically significant difference at a 5% level.*
***Indicates statistically significant difference at a 1% level.*
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Individuals receiving coverage through COBRA also more frequently have other conditions not among those making up the CCI. Notably, a greater share of COBRA claimants have high blood pressure (21 percent), high cholesterol (23 percent), and connective tissue disease (10 percent) than individuals who receive coverage through full-time employment (15 percent, 14 percent, and 5 percent, respectively), among many others, seen above in Figure 5. These differences in proportions, too, are statistically significant at a 1 percent level. Many of these chronic conditions require the use of specialist visits and prescriptions to manage successfully. It comes as little surprise, then, that individuals who recently separated from a job might choose to take up COBRA benefits rather than continue without insurance until finding a new job.

Even among family coverage, those receiving health insurance through COBRA benefits tend to be less healthy on average than those receiving insurance through a full-time worker. The average CCI for an individual with family coverage through a full-time employee is 0.20, compared with 0.31 for an individual covered by COBRA family insurance, shown above in Figure 4. The average CCI for those covered by a family plan is dragged down by relatively healthier family members; in a four-person family, a former worker may choose to enroll in COBRA even if only one of their family members — say, a partner or a dependent — expects to incur significant medical expenditures, even if the other family members are quite healthy. That the difference in CCI is more than 50 percent higher for COBRA enrollees than full-time-employee coverage enrollees is a surprising result (and this result is significant at a 1 percent level). Much like their counterparts with individual coverage, people covered with family COBRA coverage are less healthy than those covered by a full-time employee, which again suggests that anticipated medical costs play a role in choosing to take up COBRA benefits.

… and They Use Care More Frequently

In the context of COBRA enrollees systematically spending more and being systematically less healthy, it is not a surprising result that they are also heavier users of both inpatient and outpatient services.

Among people with individual coverage, COBRA enrollees more frequently used each outpatient service we tracked than did people receiving coverage through a full-time worker, as seen below in Figure 6. All differences are significant at a 1 percent level. Most notably, the average COBRA enrollee with individual coverage used psychotherapist services nearly four times more frequently than the average person with coverage through a full-time employee and physical therapy services more than two times as frequently. COBRA beneficiaries also fill prescription drugs 73 percent more frequently than those covered by a full-time worker. This lends additional credence to the theory that people enroll in COBRA if they know they will be facing significant medical expenditures. There are similar disparities in the usage of inpatient services by people covered by family plans under COBRA and by people under full-time-employee coverage, also shown below in Figure 6. In particular, COBRA beneficiaries spend much more time in hospitals: Inpatient hospital days are 78 per 100 enrollees for COBRA beneficiaries vs. 16.5 per 100 enrollees for those with coverage through full-time employees. We observe similar disparities in spending for inpatient and outpatient services between COBRA beneficiaries and those covered by insurance through a full-time employee, shown below in Figure 7.

Figure 6
Use of Health Care Services, by Source of Coverage

	Individual Coverage			Family Coverage		
Variable	**Full-Time Employee**	**COBRA**		**Full-Time Employee**	**COBRA**	
Inpatient Hospital Admissions (per 100 enrollees)	3.8	10.2	**	4.8	4.6	
Inpatient Hospital Days (per 100 enrollees)	16.5	78.0	**	21.1	27.0	
Emergency Department Visits (per 100 enrollees)	35.8	40.0		34.1	30.6	**
Office Visits	4.1	6.7	**	3.9	4.9	**
Primary care physican	1.9	2.5	**	2.0	2.1	**
Specialist physician	2.1	4.2	**	1.9	2.8	**
Prescription Drug Fills	17.3	30.0	**	11.9	17.0	**
Blood Test, Panel	1.3	2.2	**	0.9	1.3	**
EKG, Echocardiogram, Stress Test	0.3	0.5	**	0.2	0.3	**
X-Ray	0.4	0.7	**	0.3	0.4	**
CAT Scan	0.1	0.2	**	0.1	0.1	**
MRI	0.1	0.2	**	0.1	0.1	**
Chiropractor Visits	0.5	0.8	**	0.4	0.6	**
Physical Therapist Visits	1.1	2.5	**	0.9	1.7	**
Psychotherapist Visits	0.6	2.4	**	0.7	1.3	**
Musculoskeletal Surgery	0.02	0.04	**	0.02	0.03	**

**Indicates statistically significant difference at a 5% level.*
***Indicates statistically significant difference at a 1% level.*
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 7
Spending on Health Care Services, by Type of Service and Source of Coverage

	Individual Coverage			Family Coverage		
Variable	**Full-Time Employee**	**COBRA**		**Full-Time Employee**	**COBRA**	
Total	$6,724	$18,756		$5,652	$8,676	**
Inpatient Hospital	$1,111	$4,313	**	$1,194	$1,584	
Emergency Department	$306	$451		$281	$271	**
Office Visits						
Primary care physican	$223	$310	**	$235	$258	**
Specialist physician	$258	$526	**	$227	$357	**
Outpatient Services						
Diagnostic	$1,011	$2,067	**	$797	$1,204	**
Surgery	$470	$1,020	**	$393	$631	**
Chemotherapy	$155	$710	**	$103	$261	
Medical supplies, devices, and durable medical equipment	$128	$360	**	$117	$192	**
Dialysis	$83	$879		$40	$20	
Radiation therapy	$62	$218		$38	$90	
Other outpatient services	$894	$2,702	**	$786	$1,426	**
Prescription Drugs						
Prescription drug spending from pharmacy claims	$1,707	$4,130	**	$1,153	$1,905	**
Specialty drugs spending from medical claims	$207	$723	**	$151	$287	
Other non-specialty drug spending from medical claims	$127	$360	**	$153	$203	**
Blood Test, Panel Costs	$110	$214	**	$83	$122	**
EKG, Echocardiogram, Stress Test Costs	$56	$107	**	$45	$66	**
X-Ray Costs	$48	$85	**	$43	$53	**
CAT Scan Costs	$92	$193	**	$71	$100	**
MRI Costs	$83	$199	**	$72	$118	**
Chiropractor Costs	$22	$32	**	$17	$23	**
Physical Therapist Costs	$130	$313	**	$105	$213	**
Psychotherapist Costs	$75	$397	**	$95	$227	**
Musculoskeletal Surgery Costs	$128	$282	**	$113	$185	**

Notes: Values are proportions unless denoted otherwise.
**Indicates statistically significant difference at a 5% level.*
***Indicates statistically significant difference at a 1% level.*
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

However, the Spending Gap is Shrinking

While COBRA claimants clearly spend more on health care than do people covered by a full-time employee, the difference between the two groups has been shrinking of late. Shown below in Figure 8, we see that in 2013, the average spending of a COBRA claimant with individual coverage was $18,794, compared with only $5,504 for a full-time employee with individual coverage, or 241 percent higher. There is a smaller discrepancy for family plans: Those covered by a COBRA family plan spent on average 54 percent more at the household level than those covered by a full-time employee.

Figure 8
Total Health Care Spending, by Coverage Status, 2013–2018

	2013	2014	2015	2016	2017	2018
COBRA						
Individual coverage	$18,794	$19,494	$19,826	$19,545	$18,582	$18,752
Family (household level)	$23,507	$25,397	$25,929	$26,803	$26,213	$26,638
Family (individual level)	$7,765	$8,469	$8,649	$8,670	$8,429	$8,676
Full-Time Employed						
Individual coverage	$5,504	$5,631	$5,174	$6,145	$6,320	$6,724
Family (household level)	$15,271	$15,905	$15,141	$17,583	$18,808	$19,325
Family (individual level)	$4,457	$4,653	$4,437	$5,124	$5,477	$5,652

Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

After slight increases in 2014 and 2015, this ratio has slowly decreased over time. While there is still a significant discrepancy in spending between the two groups, by 2018, individual-coverage COBRA claimants spent 179 percent more than those covered by a full-time employee. For family plans, COBRA claimants spent 38 percent more at the household level than those covered by a full-time employee.

This result could be driven by the implementation of the ACA exchanges. While there are manifold variables and interactions that influence the decision to take up COBRA benefits, the implementation of ACA exchanges may have fundamentally altered the makeup of who chooses to take up COBRA benefits. In particular, high spenders who have recently separated from their employers may no longer view taking up COBRA benefits as the only way for them to meet their health care needs. Furthermore, the cost-sharing subsidies available to those individuals in families with incomes less than 250 percent of the federal poverty level (FPL) may have driven some of the highest-use COBRA beneficiaries to ACA exchanges soon after they became available.

Subsidies for COBRA

On May 15, 2020, the U.S. House of Representatives passed the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, which would provide a 100 percent federal subsidy of COBRA premiums between March 1, 2020, and January 31, 2021, for individuals and their dependents who have lost employment-based health benefits. As of this writing, the U.S. Senate has not voted on the HEROES Act.

In general, employers, insurers, and health care providers support COBRA subsidy proposals. Employers and insurers are in favor of COBRA subsidies because those subsidies would mitigate adverse selection. Subsidies would help get more healthy people to enroll in COBRA, offsetting our findings that COBRA beneficiaries are more likely than active workers and their families to have chronic health conditions and use more health care services. Health care providers support COBRA subsidies as a way to keep people on private health insurance. Because Medicaid pays providers less than private payers, any patient mix shift away from private to public coverage will reduce provider income. Similarly, increases in the uninsured population are associated with increases in uncompensated care among health care providers. It is the main reason why health care providers may choose to pay premiums on behalf of some COBRA beneficiaries.

When ARRA was passed in 2009, the Congressional Budget Office (CBO) estimated $25 billion in subsidies would be provided to COBRA beneficiaries between 2009 and 2012, with $14 billion in subsidies provided in 2009. ARRA was also expected to assist 7 million people with COBRA subsidies during 2009.[11] In a report conducted for the U.S. Department of Labor, researchers found that COBRA subsidies associated with the ARRA did not result in a large increase in COBRA coverage. Among subsidy-eligible COBRA beneficiaries, 35.4 percent took COBRA.[12] Among those not eligible for the COBRA subsidy, 30.3 percent took COBRA. The subsidy may have only had a small effect, because even after the subsidy, COBRA premiums may not have been affordable for many families, especially at a time when they had seen a decline in income. In 2009, health insurance premiums averaged $4,824 a year for individual coverage and $13,375 for

family coverage.[13] After the subsidy, premiums would be $1,688 for individual coverage and $4,681 for family coverage. Furthermore, whereas premiums for current workers' employment-based coverage either are excluded from taxable income or reduce taxable income, COBRA premiums are generally not tax deductible. A 100 percent COBRA subsidy is expected to have a much larger effect than the ARRA subsidy of 65 percent. The study also found that the COBRA subsidy impacted incentives to return to work, but the impact was small, suggesting COBRA subsidies were a minor disincentive.

It is important to note, however, that estimates of the effect of the subsidies on take-up of COBRA coverage varies. Aon reported in August and December 2009 that COBRA enrollments had doubled, from 19 percent of eligible individuals to nearly 40 percent.[14] In contrast, Ceridian found that COBRA enrollment increased from 12.4 percent to 17.7 percent.[15] And, Aon reported that COBRA enrollment increased from 14.1 percent to 15.9 percent, while Deseret Mutual saw enrollment increase from 5.3 percent to 22.5 percent.[16] Graetz, et al. (2012) reported that 38 percent of laid-off workers eligible for the subsidy enrolled in COBRA. The Treasury Department reported in May 2010 that between 25 percent and 33 percent of eligible unemployed workers received subsidized COBRA coverage (these estimates are based on a survey conducted in New Jersey).[17]

While the estimates reported above vary as to the impact of the COBRA subsidy, in June 2010, the Treasury Department released its interim report on the program, as required by law. The report concluded that as many as 2 million households benefitted from the COBRA subsidy during 2009 at a cost of over $2 billion.[18]

There are reasons, however, to doubt that 2 million households benefitted from the subsidy:

- The report was based on employer reporting and recognizes that from quarter to quarter there may be double counting.
- If $2 billion were used to subsidize 2 million households, it would imply that each household received an average $1,000 subsidy, which is much lower than the expected annual subsidy. With premiums averaging $4,824 for employee-only coverage and $13,375 for family coverage in 2009, the 65 percent subsidy would average $3,136 for employee-only coverage and $8,694 for family coverage.
- Some of the individuals who benefitted from the premium may have already elected COBRA coverage at the time that ARRA was passed. While these individuals clearly benefitted from the subsidy, they did not initially elect COBRA coverage because of the subsidy. However, they may have continued COBRA longer than they otherwise would have because of the subsidy.

The HEROES Act, however, proposes a 100 percent subsidy for COBRA premiums. This will likely have a larger effect than those observed under the 65 percent subsidy offered under ARRA.[19]

The Case for Subsidies

Are They Necessary?

Whether it is necessary to provide COBRA subsidies today is a matter of debate. When COBRA subsidies were last provided in 2010, the ACA marketplace did not yet exist. Subsidies for ACA marketplace coverage for those individuals with income below 400 percent of the FPL were a few years away from being available. And cost-sharing reductions or subsidies that help cover out-of-pocket expenses such as deductibles, copayments, and coinsurance for individuals with income below 250 percent of the federal poverty level were also a few years away from being available.

Today, individuals eligible for COBRA can get health coverage on ACA exchanges. They cannot be denied coverage for a pre-existing condition, nor can they be charged a higher premium because of the presence of a pre-existing condition. Individuals under 400 percent of FPL get subsidized coverage and those with incomes below 250 percent of FPL get subsidies to help cover out-of-pocket expenses.

Would They Negatively Impact Employer Coverage?

In today's recession, some employers have continued to pay premiums for laid-off and furloughed employees, at least for some period of time. The availability of a substantial government-provided COBRA subsidy could incentivize employers to cut off health benefits immediately.

Individuals May Prefer Subsidized COBRA Over the ACA

There are a number of reasons why individuals may prefer COBRA coverage over coverage in the ACA exchanges. For example, in the ACA exchanges, covered individuals would have to meet a new deductible, and any payments toward their annual limit on their employer-based coverage would not count toward their ACA coverage. And, if they returned to their employer before the end of the year, their spending through their ACA plans would not count toward their employer-based coverage cost-sharing accumulators. Additionally, while subsidies are available for premiums and cost sharing in the ACA exchanges for individuals whose incomes are below qualifying levels, if individuals expect to return to work, their annual salary may disqualify them from those subsidies. Individuals with chronic conditions may prefer COBRA coverage if that coverage allows them to maintain their relationship with a health care provider.

Conclusion

COBRA benefits are unique in that potential beneficiaries do not have to elect coverage immediately after separating from an employer. This presents a unique adverse selection mechanism. Potentially, only those who have high medical expenses (or those who want to cover someone who does, such as a spouse or dependent) will elect coverage. However, the extent to which people covered by COBRA are higher health care spenders than those who receive coverage through a full-time employee has to this point been recently unexamined.

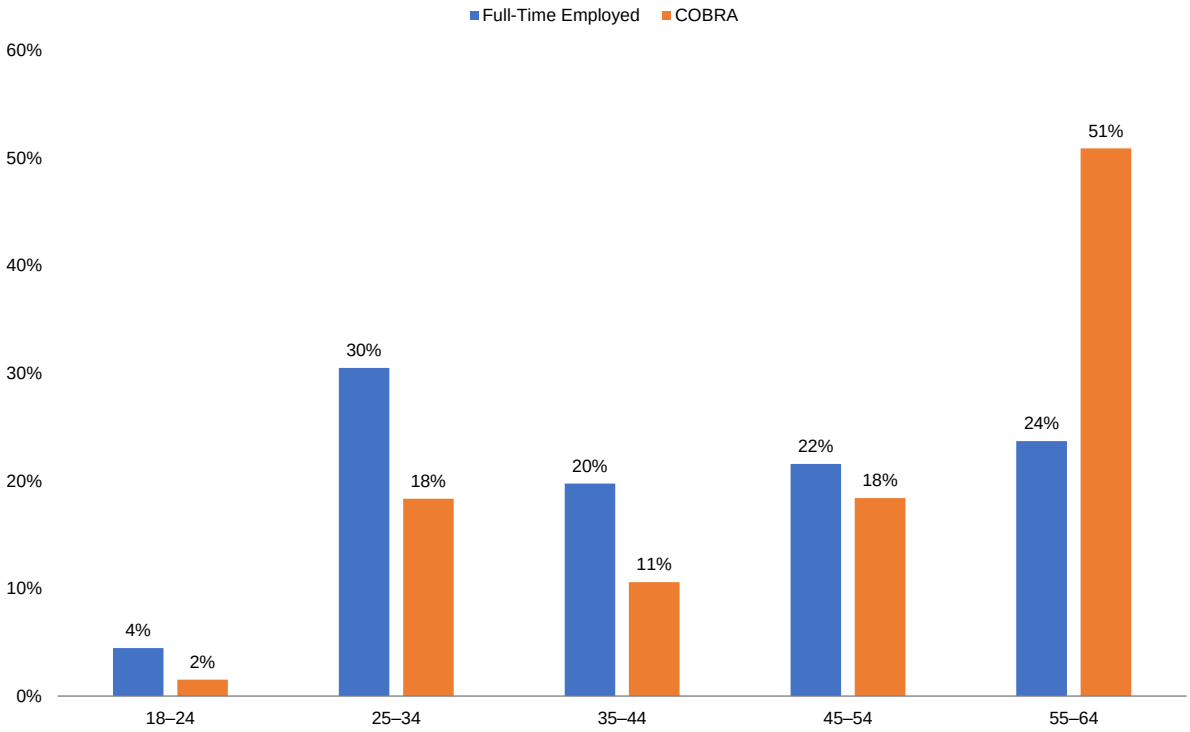
People with coverage through COBRA are systematically different from those who receive coverage through a full-time worker, regardless of individual or family coverage. They are more likely to be older and female, and households with family coverage tend to have older adults and more covered dependents. Enrollees in COBRA spend more on health care on average than people with full-time-employee coverage, and this held true for both individual coverage and family coverage insurance plans. Unsurprisingly, COBRA enrollees' higher spending was reflected in their higher usage of inpatient and outpatient services as well as prescription drugs. This evidence suggests that the decision to take up COBRA benefits is affected by an individual's — or, if applicable, their family's — anticipated medical costs.

The implementation of ACA exchanges appears to have somewhat mitigated adverse selection against employer plans. No longer do newly separated workers have COBRA as their only choice for health insurance (notwithstanding other insurance options such as Medicaid). Rather, ACA exchanges are a viable alternative to maintain health insurance coverage. As a result, the ratio of spending by COBRA enrollees to spending by those covered by a full-time worker with an employer-sponsored plan has decreased steadily over time, and this trend holds for both individual coverage and family coverage.

These findings have significant implications for both employers and policymakers alike. Since, on average, people who receive coverage through COBRA are systematically higher spenders, extending subsidies for newly separated workers to enroll in COBRA could be beneficial to the extent that policymakers and employers wish to improve the risk pool for COBRA claimants. The systematically higher spenders who have historically claimed COBRA benefits might instead be balanced out by marginally healthier former workers who choose to enroll on account of receiving a subsidy. The ratio of spending by those covered by COBRA to those covered by a full-time employee has dropped over time, however, indicating that the adverse selection mechanism has already been slightly moderated.

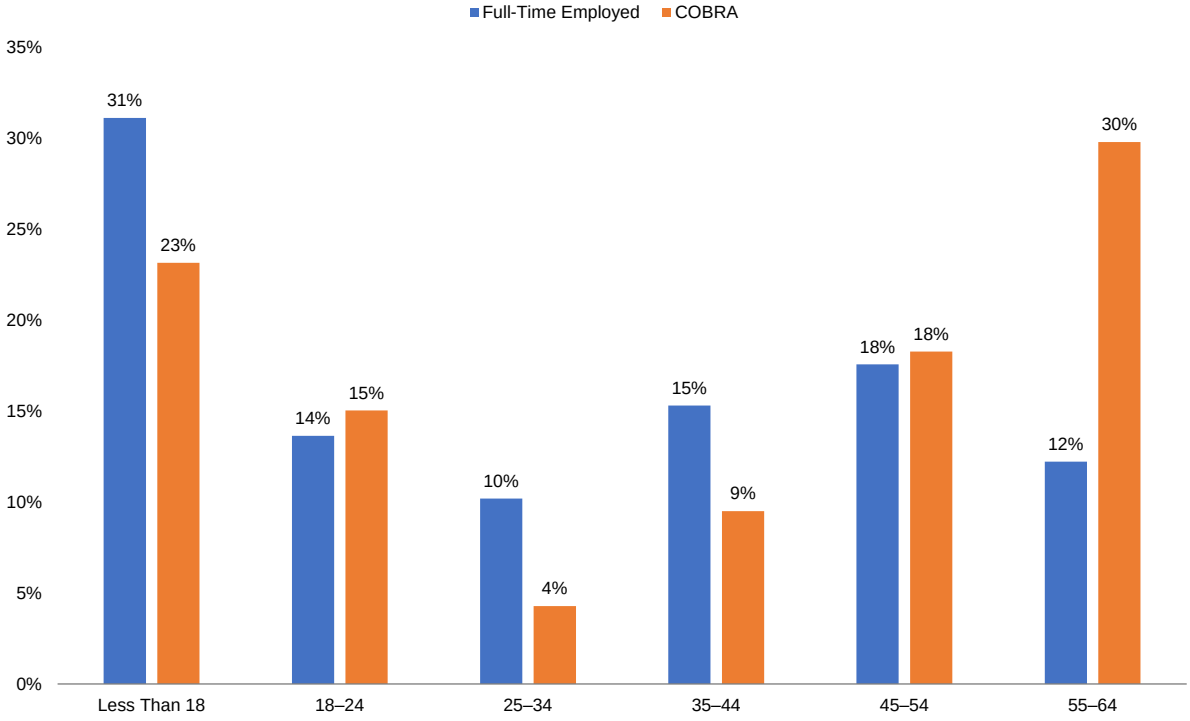
Appendix

Appendix Figure 1
Age Distribution, Among Individuals With Employee-Only Coverage, by Coverage Status, 2018



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Appendix Figure 2
Age Distribution, Among Individuals With Family Coverage, by Coverage Status, 2018



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Appendix Figure 3

Presence of Health Conditions, Individual Coverage, by Full-Time Employee (FTE) and COBRA Coverage

Variable	FTE (N=145,052)	COBRA (N=16,437)	p-value
Charlson Comorbidity Index (CCI)	0.32	0.66	<0.01**
CCI Indicators:			
Acute Myocardial Infarction	0.00	0.01	0.32
Congestive Heart Failure	0.01	0.02	0.02*
Peripheral Vascular Disease	0.01	0.02	<0.01**
Cerebrovascular Disease	0.01	0.03	<0.01**
Dementia	0.00	0.00	0.68
Chronic Obstructive Pulmonary Disease	0.05	0.08	<0.01**
Rheumatoid Disease	0.01	0.02	0.03*
Peptic Ulcer	0.00	0.00	0.57
Mild Liver Disease	0.02	0.03	<0.01**
Diabetes (With or Without Complications)	0.08	0.11	<0.01**
Hemiplegia or Paraplegia	0.00	0.00	0.59
Renal Disease	0.01	0.02	<0.01**
Cancer (non-metastatic or metastatic)	0.02	0.06	<0.01**
Moderate/Severe Liver Disease	0.00	0.00	0.63
AIDS	0.00	0.01	0.38
Other Chronic Conditions and Selected CCS* Indicators:			
Hypertension	0.15	0.21	<0.01**
Dyslipidemia	0.14	0.23	<0.01**
Schizophrenia/Bipolar, Depression, Anxiety, Mood Disorders	0.07	0.14	<0.01**
Spondylosis; Intervertebral Disc Disorders; Other Back Problems	0.07	0.13	<0.01**
Rheumatoid Arthritis and Related Disease	0.00	0.01	0.15
Multiple Sclerosis	0.00	0.00	0.68
Regional Enteritis and Ulcerative Colitis	0.00	0.01	0.35
Lower/Upper Respiratory Disease/Infection	0.08	0.11	<0.01**
Asthma/COPD, Acute Bronchitis	0.02	0.03	<0.01**
Thyroid Disorders	0.03	0.04	<0.01**
Endocrine Disorders	0.01	0.02	0.20
Nervous System Disorders	0.02	0.05	<0.01**
Osteoarthritis	0.02	0.04	<0.01**
Non-Traumatic Joint Disorders	0.05	0.09	<0.01**
Connective Tissue Disease	0.05	0.10	<0.01**
Childbirth	0.00	0.00	1.00

*Notes: * Clinical Classification System (CCS) classified individuals into 285 mutually exclusive and clinically homogeneous categories. More information can be found in Elixhauser, Steiner and Palmer (2013).*

**Indicates statistically significant difference at a 5% level.*

***Indicates statistically significant difference at a 1% level.*

Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Appendix Figure 4

Presence of Health Conditions, Family Coverage, by Full-Time Employee (FTE) and COBRA Coverage

Variable	FTE (N=649,944)	COBRA (N=30,811)	p-value
Charlson Comorbidity Index (CCI)	0.20	0.31	<0.01**
CCI Indicators:			
Acute Myocardial Infarction	0.00	0.00	0.63
Congestive Heart Failure	0.00	0.01	0.34
Peripheral Vascular Disease	0.01	0.01	0.21
Cerebrovascular Disease	0.01	0.01	0.12
Dementia	0.00	0.00	0.91
Chronic Obstructive Pulmonary Disease	0.05	0.06	0.63
Rheumatoid Disease	0.01	0.01	0.18
Peptic Ulcer	0.00	0.00	0.91
Mild Liver Disease	0.01	0.02	0.09
Diabetes (With or Without Complications)	0.04	0.06	<0.01**
Hemiplegia or Paraplegia	0.00	0.00	0.63
Renal Disease	0.00	0.01	0.41
Cancer (non-metastatic or metastatic)	0.02	0.03	<0.01**
Moderate/Severe Liver Disease	0.00	0.00	0.63
AIDS	0.00	0.00	0.91
Other Chronic Conditions and Selected CCS* Indicators:			
Hypertension	0.08	0.11	<0.01**
Dyslipidemia	0.09	0.15	<0.01**
Schizophrenia/Bipolar, Depression, Anxiety, Mood Disorders	0.06	0.09	<0.01**
Spondylosis; Intervertebral Disc Disorders; Other Back Problems	0.06	0.08	<0.01**
Rheumatoid Arthritis and Related Disease	0.00	0.01	0.34
Multiple Sclerosis	0.00	0.00	0.63
Regional Enteritis and Ulcerative Colitis	0.00	0.00	0.91
Lower/Upper Respiratory Disease/Infection	0.10	0.11	0.05
Asthma/COPD, Acute Bronchitis	0.02	0.02	0.91
Thyroid Disorders	0.02	0.03	0.01*
Endocrine Disorders	0.01	0.01	0.34
Nervous System Disorders	0.02	0.03	<0.01**
Osteoarthritis	0.01	0.02	<0.01**
Non-Traumatic Joint Disorders	0.04	0.06	<0.01**
Connective Tissue Disease	0.04	0.07	<0.01**
Childbirth	0.01	0.00	0.18

*Notes: * Clinical Classification System (CCS) classified individuals into 285 mutually exclusive and clinically homogeneous categories. More information can be found in Elixhauser, Steiner and Palmer (2013).*
**Indicates statistically significant difference at a 5% level.*
***Indicates statistically significant difference at a 1% level.*
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

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Endnotes

[1] https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

[2] According to the National Bureau of Economic Research (NBER), the U.S. entered a recession in February 2020. See https://www.nber.org/cycles/june2020.pdf

[3] However, the extent to which people covered by COBRA are higher spenders than those who receive coverage through a full-time employee has to this point been recently unexamined.

[4] See https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09399.pdf

[5] US Treasury Department, Office of Economic Policy, "COBRA Insurance Coverage Since the Recovery Act: Results from New Survey Data," 2010.

[6] See https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/

[7] US Treasury Department, Office of Economic Policy, "COBRA Insurance Coverage Since the Recovery Act: Results from New Survey Data," 2010.

[8] Only 13 percent of HSA owners make the maximum contribution. See https://www.ebri.org/docs/default-source/fast-facts/ff-311-hsa-30july18.pdf?sfvrsn=cf17302f_2

[9] Ten of the 17 conditions are given a weight of one. Seven of the 17 conditions receive a weight of between two and six.

[10] Family coverage plans often cover dependents, which will pull down the average age of individuals covered by family plans.

[11] See https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1696179

[12] See https://www.dol.gov/sites/dolgov/files/EBSA/researchers/analysis/health-and-welfare/evaluation-of-the-arra-cobra-subsidy.pdf

[13] See Exhibits 6.3 and 6.4 in https://www.kff.org/wp-content/uploads/2013/04/7936.pdf

[14] See https://aon.mediaroom.com/hewitt-new-release-archive?item=625 and https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1696179

[15] See http://hr.cch.com/news/benefits/102909.asp

[16] See www.urban.org/UploadedPDF/412172-laid-off-workers.pdf

[17] See https://www.treasury.gov/resource-center/economic-policy/Documents/cobra%20final%20report.pdf

[18] U.S. Department of Treasury, "Interim Report to The Congress on COBRA Premium Assistance," June 2010.

[19] The study also found that the COBRA subsidy impacted incentives to return to work but that the impact was small, suggesting COBRA subsidies were a minor disincentive.

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