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IN FOCUS

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Health Insurance Options for Terminated Employees

Many Americans have health insurance coverage that is provided through an employment setting. In light of the economic repercussions of the COVID-19 pandemic, many Americans may be terminated from jobs through which they receive health insurance. Such individuals may need to identify another source of health insurance to remain enrolled in plans that cover COVID-19-related services.

Three potential comprehensive coverage options for terminated employees include the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, individual health insurance coverage, and Medicaid. An individual's eligibility for these coverage options depends on a number of factors (e.g., economic circumstances, family composition, federal/state policies). Even if an individual is eligible for such coverage, the costs associated with some options may be prohibitive given the individual's loss of income due to unemployment.

This In Focus provides a brief overview of eligibility, benefits, and costs associated with these different health insurance coverage types. It primarily discusses coverage options for terminated employees who can no longer access their former employer-sponsored health insurance.

For married couples in which one spouse's termination results in the loss of his/her (or his/her family's) health insurance coverage, the spouse (or family) may be able to enroll in coverage through the other spouse's employer if the other spouse is working and his/her employer offers health insurance coverage. In general, employers offering health insurance benefits to their employees are obligated to offer employees who were enrolled in coverage (not sponsored by the employer) a special enrollment period (SEP) in the event that the employee (and/or family) loses his/her other coverage and meets certain criteria.

COBRA Continuation Coverage

COBRA continuation coverage provides terminated employees, their spouse, and their dependent children with temporary access to a former employer's health insurance.

Eligibility

To be eligible for COBRA continuation coverage, an individual must satisfy the following criteria: (1) work (or be the spouse/dependent child of someone who works) for an employer that must offer COBRA continuation coverage, (2) experience a qualifying event, and (3) be covered by his/her former employer's sponsored health plan on the day before the qualifying event occurs.

All employers that sponsor health insurance benefits are subject to COBRA requirements, except employers with fewer than 20 employees; church plans; and federal, state, and local governments. In general, most large employers will be subject to COBRA requirements as a result of being subject to the employer shared responsibility provisions, which incentivize large employers to offer health insurance coverage to their full-time employees.

For COBRA purposes, an employee's termination for any reason other than "gross misconduct" is considered a qualifying event for the former employee and his/her spouse or dependent child if such event causes a loss in the former employer's sponsored coverage.

A qualified individual must be allowed to elect COBRA coverage within (at least) 60 days from the later of two dates: the date coverage would be lost due to the qualifying event or the date the beneficiary is sent notice of his/her right to elect COBRA coverage.

Coverage

COBRA coverage must be identical to the coverage available to *similarly situated* active employees. This is often the same coverage that the individual had prior to the qualifying event.

For terminated employees, coverage generally may last for at most 18 months. Employees may terminate their coverage at any point, and employers may terminate COBRA coverage early for specified reasons (e.g., an employer ceases to maintain any group health plan due to going out of business).

Employers are not required to pay the cost of COBRA coverage, though they may choose to do so. As such, COBRA continuation coverage may be more expensive than other coverage options. Employers are permitted to charge the covered individual 100% of the premium (i.e., both the portion paid by the employee and the portion paid by the employer), plus an additional 2% administrative fee.

Individual Health Insurance Coverage

Individuals and families may purchase individual health insurance coverage directly from an issuer in the individual market. The individual market includes the health insurance exchanges (marketplaces), but individuals also can purchase coverage outside of the exchanges.

Eligibility

In general, individuals may purchase individual health insurance coverage sold in the state in which they reside. For exchange coverage, state residents also must be citizens or have other lawful status, and they must not be incarcerated (except those pending disposition of charges).

Federal law requires individual issuers to accept all insurance applicants but may restrict enrollment to specified times, such as open and special enrollment periods. Terminated employees (and their dependents) who lose health coverage due to loss of employment (not due to employee's gross misconduct) qualify for an individual market SEP. Such individuals may enroll in a plan offered in or out of an exchange during the SEP.

Coverage

Individual health insurance coverage generally must comply with numerous federal and state requirements related to plan features and consumer protections. Included among the federal requirements are coverage for essential health benefits (EHBs), coverage for preexisting health conditions, and a prohibition on using health status as a factor in eligibility or premiums.

Individuals who enroll in exchange coverage and meet income and other eligibility criteria may receive financial assistance through a federal tax credit and cost-sharing subsidies. The credit reduces an eligible individual's insurance premium; the amount varies from person to person. Individuals must have household incomes that generally fall between 100% and 400% of the federal poverty level (FPL) to be eligible for the credit. There are two forms of cost-sharing subsidies: one reduces costs for eligible individuals who typically use a lot of health care; the other reduces costs for all eligible individuals. Eligible individuals must have household incomes between 100% and 250% FPL and may receive both types of cost-sharing subsidies.

Medicaid

Medicaid, authorized in Title XIX of the Social Security Act (SSA), is a federal-state program that jointly finances medical and related services to a diverse low-income population. States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs.

Medicaid provides a health care safety net for low-income populations. During periods of economic downturn, Medicaid enrollment increases at a faster rate because job and income losses make more people eligible. In addition, those who were previously eligible but not yet enrolled may seek enrollment.

Eligibility

To be eligible for Medicaid, individuals must meet both categorical (i.e., a group listed in statute) and financial (e.g., income, assets) criteria in addition to requirements regarding residency, immigration status, and U.S. citizenship. Historically, Medicaid eligibility has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, since 2014, 36 states and the District of Columbia have taken up the option to cover non-elderly adults with income up to 133% of FPL through the Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion. For some eligibility groups or *pathways*, state coverage is mandatory (e.g., low-income children up to 133% FPL), whereas for others it is optional (e.g., pregnant women with annual income between 133% and 185% of FPL). This results in variability from state to state. For example, adult coverage differs between states with and without the ACA Medicaid expansion.

Medicaid eligibility determinations may occur at any time, are based on monthly income, and generally apply for 12 months. An individual may be retroactively Medicaid eligible for up to three months prior to the month of application, if the individual received covered services and would have been eligible had he or she applied during that period. States also may rely on enrollment facilitation strategies (e.g., presumptive eligibility) to immediately enroll individuals for a temporary period until a formal eligibility determination is made. The Centers for Medicare and Medicaid Services (CMS) has identified additional flexibilities around the timeliness of Medicaid eligibility determinations given the anticipated demand associated with the COVID-19 pandemic. CMS also directs states to screen for eligibility and enroll individuals in subsidized coverage available through the exchanges, Medicaid (including eligibility for Medicaid COVID-19 testing for the uninsured at state option), or the State Children's Health Insurance Program (CHIP). This requirement aims to connect uninsured individuals to the appropriate coverage, if one is available.

Coverage

Medicaid coverage includes a variety of primary and acute-care services as well as long-term services and supports and benefit coverage varies across states. Not all Medicaid enrollees have access to the same set of services. An enrollee's eligibility pathway determines the available services, with some pathways providing access to limited coverage (e.g., COVID-19 testing).

Most Medicaid beneficiaries generally receive services through traditional Medicaid—a comprehensive array of required or optional services listed in statute. However, states also may furnish Medicaid through alternative benefit plans (ABPs). Under ABPs, states must provide comprehensive benefit coverage that is based on a coverage benchmark rather than a list of discrete items and services as under traditional Medicaid. Unlike traditional Medicaid benefit coverage, coverage under an ABP must include at least the EHBs that certain plans in the private health insurance market are required to furnish. Beneficiary cost sharing (e.g., premiums and co-payments) is limited under the Medicaid program.

For more information on the topics covered in this product, seeCRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*; CRS Report R44065, *Overview of Health Insurance Exchanges*; CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies*; and CRS Report R43357, *Medicaid: An Overview*.

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