



## **The Impact of Lifetime Limits**

*Prepared for*

**National Hemophilia Foundation on behalf of the:**

**Raise the Caps Coalition**

**(See full list of members inside)**

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**Raise the Caps Coalition Members**

Alpha-1 Advocacy Alliance  
Alpha-1 Association  
Alpha-1 Foundation  
American Autoimmune Related Diseases Association  
American Heart Association/American Stroke Association  
American Pain Foundation  
Autism Society of America  
Baxter Bioscience  
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## The Impact of Lifetime Limits

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## Executive Summary

PricewaterhouseCoopers was engaged by the National Hemophilia Foundation on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders to conduct a study of lifetime limits under employer-sponsored medical plans. These include several high-cost conditions like hemophilia, Gaucher's disease, immune deficiencies, certain cancers and others where annual costs in the hundreds of thousands of dollars or more are not unusual. Specifically, the study examines the prevalence of lifetime limits, the number of people affected by them, and the costs of increasing, or removing, lifetime limits from health plans. The findings are based on public data, surveys of major insurers, and PwC actuarial modeling.

### Prevalence of Lifetime Limits

- About 55 percent of individuals with employer provided health insurance are subject to lifetime limits, or 91 million people in 2009. The proportion of individuals with employer coverage, who have no lifetime limits increased substantially between 2000 and 2007.
- The most common lifetime limits are \$1 million or \$2 million. More than 20 percent of people covered by employer plans are subject to lifetime limits of \$1 million; another 32 percent are subject to limits of \$2 million or more.
- Employers that self-insure are more likely to have plans with lifetime limits.
- PwC estimates that in 2009 approximately 20,000 to 25,000 people are no longer covered by their employer-sponsored plans because of lifetime limits.

### Cost of Removing Lifetime Limits

- Increasing lifetime limits from \$1 million to \$5 million would increase premiums, on average, by 0.6 percent to 0.8 percent (approximately \$3 per month for typical single plan, \$8 per month for family plan).
- Increasing lifetime limits from \$2 million to \$5 million would increase premiums, on average, by 0.25 percent to 0.35 percent (less than \$2 per month for typical single plan, \$4 per month for family plan).
- Extending the limits from \$5 million to \$10 million would increase premiums on average by less than 0.1 percent.

### Illustrative Impact of Lifetime Limits in 2019

- If lifetime limits are not increased, the number of individuals who are no longer covered by their employer-sponsored plans because of lifetime limits will increase exponentially as healthcare costs continue to rise.
- According to the U.S. Department of Health and Human Services, healthcare costs per capita are projected to rise at about 6 percent annually, or about 80 percent over the next 10 years.
- At this rate of increase, PwC estimates approximately 300,000 people (0.3 percent of the people with lifetime limits) would be affected by lifetime limits in 2019 if current limits were not increased.

### Medicaid Savings from Increasing Lifetime Limits to \$10 Million

- Many individuals who lose insurance coverage because of lifetime limits fall back on government programs, primarily Medicaid.
- If lifetime limits were increased to \$10 million, PwC estimates that Medicaid programs would save more than \$1 billion in 2010.

## I. Background

PricewaterhouseCoopers was engaged by the National Hemophilia Foundation on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders to conduct a study of lifetime limits under employer-sponsored medical plans. Specifically, the study examines the prevalence of lifetime limits, the number of people who are affected by them, and the costs of increasing or removing lifetime limits from health plans.

Lifetime limits are provisions of many insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. For example, a health plan might specify that once \$1 million in benefits are paid out, the insurance plan no longer will pay for any claims for that enrollee. An individual may reach the limit in one year in the case of a catastrophic medical conditions or an individual with chronic disease may reach the limit over five years by having \$200,000 in medical expenses each year. The latter situation is associated with diseases, such as hemophilia, which have high annual treatment costs.

People who have spending that exceed health plan limits have to find other ways to pay for medical costs, which involves a combination of paying more out of pocket, finding new public or private insurance sources (often through Medicaid) and curtailing medical care. Medicaid has income and asset limits so it may take months or years to "spend down" assets and become eligible for Medicaid. Some people are able to start over with new insurance plans as a result of job changes or insurance changes initiated by their employers. Some of these individuals qualify for Medicare after being disabled for two years.

The National Hemophilia Foundation, on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders, asked PricewaterhouseCoopers to estimate the following aspects of lifetime limits:

- Prevalence of lifetime limits including number of people whose health plans include them as well as how many people are affected by the limits;
- How the lifetime limits and the number of people affected by them have changed over time;
- The cost of removing lifetime limits in terms of increases in premium costs to employers; and,
- The savings to public programs, most specifically Medicaid if lifetime limits were removed.

There is currently no uniform industry source of data on lifetime maximum benefit plans and cost impact. The PricewaterhouseCoopers findings are based on public data, surveys of major insurers, and PwC actuarial modeling. The following summarizes our sources:

- PwC researched the public domain for surveys and reports on lifetime maximum distributions and cost. The overall estimates were based on the 2007 Kaiser Foundation Annual Survey Report on Employer Health Benefits.
- PwC performed a survey of several major national insurance carriers in which information was collected on:
  - lifetime maximum cost impact;
  - reinsurance issues;
  - distribution of current participant enrollees by lifetime maximums;
  - employer processes when transferring vendors;
  - current and historic trend patterns (e.g., amount maximums changed).

PwC developed an actuarial model utilizing a large national claim database to develop estimates of the frequency with which covered individuals hit lifetime maximums and costs associated with their plans.

**II. Prevalence and Impact of Lifetime Limits**

PricewaterhouseCoopers reviewed several sources of information available on the prevalence of lifetime limits in employer-sponsored health insurance plans. Based on our marketplace experience, review of other benefit surveys and interviews of several major insurance carriers, the most common lifetime maximum limits for companies with at least 20 employees are \$1 million, \$2 million and unlimited.

The table below, which is based on the 2007 Kaiser Family Foundation employer survey, summarizes enrollment by plan type.<sup>1</sup> An estimated 22 percent of people covered by employer plans are subject to lifetime limits of \$1 million; another 32 percent are subject to limits of \$2 million or more. Research by PricewaterhouseCoopers suggests that most lifetime limits that are under \$2 million are set at exactly \$1 million. A majority plans with limits of \$2 million or more are set at \$2 million.

<b>Lifetime Limit</b>	<b>% of Individuals Enrolled</b>
Less than \$1 million	1%
\$1 million - less than \$2 million	22%
\$2 million or Greater	32%
Unlimited	45%

Self-insured firms are more likely to have limits than firms that buy commercial insurance. Individual firms are not able to spread the costs of high-cost cases across as many lives as commercial insurers do. In terms of the number of people affected, PwC estimates that approximately 91 million people covered by employer plans are subject to lifetime limits. PwC estimates in 2009 that approximately 20,000 to 25,000 individuals reach their lifetime limits.

The number of people who exhaust lifetime limits will increase dramatically unless the limits are increased to keep up with the growth in medical costs. For example, by the year 2019, medical costs will be 80 percent higher than 2009, assuming healthcare costs increase 6 percent annually. Unless lifetime limits are increased, the number of individuals who will lose employer-provided benefits because of lifetime limits will increase exponentially. Assuming no change in the current lifetime limits take place, PwC estimates that approximately 300,000 people (0.3 percent of individuals with lifetime limits) will reach their lifetime limits in 2019.

**III. Costs of Increasing Lifetime Limits**

When lifetime limits are increased, the total health plan costs will increase based on an increase in the claims and reinsurance cost components. The administrative component will have a minimal increase. The reinsurance cost component will increase to reflect the greater financial risk exposure assumed by the reinsurer as a result of any increase to the lifetime limit. Additionally, claims will increase as plan costs for ongoing claimants that are below the stoploss level increase.

<sup>1</sup> *Employer Health Benefits, 2007 Annual Survey*, Kaiser Family Foundation and Health Research and Education Trust, Washington, DC, 2007; available at <http://www.kff.org/insurance/7672>

PwC estimates that for 2009 the average monthly health premiums are approximately \$420 for single coverage and \$1,125 for family coverage.<sup>2</sup> Based on the size of an insurance carrier's book of business and the low overall frequency with which individuals reach lifetime limits, the cost of increasing the limits would be low (less than 1 percent of costs). As shown in the table below, PwC estimates that increasing lifetime limits from \$1 million to \$5 million would increase premiums by approximately 0.6 percent to 0.8 percent, or about \$3 per month for single coverage or \$8 for family coverage. The costs of increasing a \$2 million limit to \$5 million would increase costs by an estimated 0.25 percent to 0.35 percent, about \$1.50 for single coverage and \$3.50 for family coverage. Finally, increasing limits from \$5 million to \$10 million would increase cost by less than 0.1 percent, less than \$1 per month for either single or family coverage. Based on the current distribution of plans and their lifetime limits, we would estimate that the aggregate composite cost increase for all companies with lifetime limits would be 0.4 percent to 0.6 percent.

**The Change in Premiums to Increase Lifetime Limits**

Lifetime Limit Change	% Change	Monthly Premium Change
\$1 million to \$5 million	0.6% - 0.8%	\$3 (single) / \$8 (family)
\$2 million to \$5 million	0.25% - 0.35%	\$1.50 (single) / \$3.50 (family)
\$5 million to \$10 million	less than 0.1%	less than \$1 for single or family

Source: PricewaterhouseCoopers estimates.

While the above cost increments represent average cost increases, the increases could be greater for any specific smaller self-insured or insured experience-rated employer who has ongoing high dollar chronic claimants in their covered population.

**IV. Changes in Lifetime Limits, 1988-2007**

All aspects of lifetime limits have changed during the past two decades. Not only have lifetime limits been increased as medical costs have risen but also the number of people subject to lifetime limits has declined. The table below provides information from 1988 to 2007 showing that the percentage of people subject to lifetime limits in employer-sponsored plans has fallen from 79 percent in 1988 to 55 percent in 2007. During the same period the number of people subject to limits of less than \$1 million has decreased from 34 percent to about 1 percent.

**Prevalence of Lifetime Limits, 1988-2007**

	2007	2004	2002	2000	1993	1990	1988
Percent Unlimited	45%	49%	33%	22%	19%	22%	21%
Percent Under \$1 million	1%	1%	4%	6%	31%	22%	34%
Percent \$1 million or More	54%	50%	63%	72%	50%	56%	44%
Value of \$1 million (1988 dollars, millions)	\$3.6	\$3.1	\$2.7	\$2.3	\$1.6	\$1.3	\$1.0

Source: PricewaterhouseCoopers calculations based on data from employer surveys, 1988-2007

However, while lifetime limits have increased over the past two decades, the increases have not kept pace with increases in medical costs in all instances. If a 1988 lifetime limit of \$1 million is adjusted for the growth in healthcare costs (as shown in the last row of the table), the 2007 equivalent lifetime limit would be \$3.6 million. If we can consider that 44 percent had a lifetime limit of \$1 million or more in

<sup>2</sup> The 2007 Kaiser survey indicated average monthly premiums of approximately \$373 for single and \$1,009 for family coverage. PwC added two years of medical trend (approximately 6% per year) to the 2007 Kaiser numbers.

1988, there would need to be at least 44 percent of the populations today with a lifetime limit of \$3.6 million or more for there to be no change. However, where lifetime limits exist today, only a low percentage of those limits are greater than \$2 million. Consequently, the data suggests that at the high end of the range, lifetime limits may actually affect more people today than in 1988.

The historical data on lifetime limits does not provide a clear answer as to the changes in impact of the limits over time. Clearly fewer people are subject to lifetime limits today as compared with two decades ago. However, a lifetime limit of \$1 million, which was the most common limit in 1988, is still quite common today.

**V. Savings to Medicaid from Increasing Lifetime Limits**

People whose spending exceeds a lifetime limit under their current insurance plan will seek other sources of coverage. Those who are financially well off may be able to pay for their care without assistance but most people will turn to other public and private sources. The most common source of care for those who meet income eligibility requirements is Medicaid.

For example, data from the U.S. Centers for Disease Control and Prevention (CDC) show that people with severe hemophilia are much more likely to have Medicaid coverage than is typical in the general U.S. population. The table below shows that about 14 percent of people in the U.S. have Medicaid coverage in a typical month. On average, 19 percent of people with hemophilia list Medicaid as their source of coverage. People with severe hemophilia are even more likely to have Medicaid coverage-- 29 percent compared to 18 percent of people with mild hemophilia.

**Savings to Federal & State Medicaid Programs**

Population	Percentage
General US Population	14%
People with Hemophilia	
Mild	18%
Severe	29%

PricewaterhouseCoopers calculations based on data from the CDC ([www2a.cdc.gov/ncbddd/htcweb/](http://www2a.cdc.gov/ncbddd/htcweb/))

PwC estimated the impact of lifetime limits on the total spending under Medicaid based on the lifetime limits in place today. Based on our finding that increasing lifetime limits to \$10 million would increase premiums by 0.5 percent, we estimate that spending within the lifetime limits in 2010 would be about \$2.1 billion. Using the conservative assumption that Medicaid, absent the increase in the limits, would replace 50 percent of those benefits, Medicaid savings from increasing the lifetime limits would be more than \$1 billion in 2010 dollars. Moreover, the amount would grow over time as medical costs rise. We estimate that Medicaid would save more than \$11 billion over the next 10 years.<sup>3</sup>

<sup>3</sup> This estimate does not include spending above lifetime limits in firms with fewer than 20 employees. Small firms would likely be exempted from legislation to remove limits.