



**Addressing the Needs of High Cost Individuals: A Proposal for  
Catastrophic Insurance**  
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# Addressing the Needs of High Cost Individuals: A Proposal for Catastrophic Insurance

## Overview

There is little or no debate about the need, in a country as wealthy and compassionate as ours, to make sure that all Americans have the security of coverage that protects them from medical bills they can't afford and that provides them access to the care they need. Many experts have shown that a growing number of Americans, even those with insurance, are facing health costs that put serious financial pressure on them, especially at a time when the financial security of tens if not hundreds of millions of Americans is threatened by the nation's economic crisis.

Making sure that everyone has health insurance to protect against large medical bills is a worthwhile policy goal. Having this protection will provide peace of mind that will allow greater focus on how to improve health through wellness and preventive care. However, it is important to ensure that we help those with the greatest needs and most limited resources, and that we address our soaring healthcare costs that have accelerated to 16% of gross domestic product (GDP). These high health care costs drive 50% of families facing the diagnosis of a life threatening illness into bankruptcy.<sup>1</sup> To reduce costs, we must expand enrollment to include systems of reimbursement for all and make premiums for insurance affordable. Thus, affordable health care is a moral and fiscal imperative if we are to provide greater protection against bankruptcy. This will only be achieved in direct proportion to our ability to return to the traditional notion of insurance and making certain that coverage and benefits are sufficient to allow the patient to avoid bankruptcy due to excessive medical debt.

As a first principle, our nation must strive to protect our people from medical bankruptcy due to large medical bills that are not reimbursed. To achieve this, we recommend that there must be a cap on out-of-pocket expenses to the individual who is insured, based on a sliding income scale. We suggest the cap generally should be set at **no more than \$5,000 for individuals with self-only coverage and \$10,000 for individuals with family coverage, and these limits should be annually adjusted for inflation.**<sup>2</sup> **Subsidies should be provided to families to assure that the cap should never go higher than 10%**<sup>3</sup> of family income. Subsidies should be provided to those with an annual household income of 400 percent of federal poverty. In addition, all healthcare expenses, including premiums, copays, coinsurance, prescriptions drugs, should be included in reaching the cap on out-of-pocket expenses. NPAF urges that insurers be required to provide catastrophic coverage as part of a health insurance policy. Catastrophic coverage would be initiated when total health care expenditures by the insurer exceed \$100,000.00 which will help limit exposure to all stakeholders. This assures that healthcare is affordable to the individual which in turn will spur enrollment and spread the risk across a broader population of patients.

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<sup>1</sup> Health Affairs, "Illness and Injury as Contributors to Bankruptcy", Himmelstein, M., Warren, E., Thorne, D. and Woolhandler, S, February 2005.

<sup>2</sup> U.S. Department of the Treasury & Internal Revenue Service. "Guidance on Out-of-Pocket Spending Limits for High Deductible Health Plans", May 2008.

<sup>3</sup> Kaiser Family Foundation, "Health Care Affordability and the Uninsured," Slide 10 in the Chartpack accompanying the testimony of Diane Rowland before the House Ways and Means Committee, April 15, 2008

As a second principle, the employers and insurers providing insurance must be protected from a devastating loss, so that paying insurance claims is affordable. Insolvent insurers cannot pay any claims.

A third principle is to use the definition of insurance for healthcare coverage that we use in other sectors of the economy. In other sectors of the economy, insurance means protection against costs that people could not afford to pay without considerable financial difficulty, if at all. That is why we buy automobile insurance to protect us against collision, injury, and loss of our vehicle, or homeowner’s insurance to protect against the risk of fire, theft, or other serious and expensive damage. So, generally speaking, insurance is a small loss, i.e. the payment of a premium, to avoid a large loss, possibly devastating loss.

As a solution to catastrophic healthcare costs, we recommend a system of “back end” federal subsidies to insurers, whether a company or an employer, or a federal insurance program for catastrophic costs. Once annual healthcare expenditures for an insured individual reached a catastrophic level, the federal government would either pay for or reimburse 75% percent of the expenditure, with the insurer paying the remaining 25% to minimize moral hazard. The level of expenditures at which catastrophic begins would need to be defined. We would suggest over \$75,000 annually. Spreading the risk of catastrophic (the most expensive) claims across the population in this way would serve to lower the premium on insurance for claims below the catastrophic level, benefiting both the insurer and the insured.

### The Role of Insurance

Spreading risk is one of the main roles of health insurance. Although most people have low annual claims expenses, a small minority incur very high expenditures in any given year. Analyzing data from the Medical Expenditure Panel Survey (MEPS) from 2006, most of health care spending among the privately insured population is accounted for by a small number of people.

<b>Table 1: Health Expenditure Distribution</b>					
<b>2006 Total Expenditure Category</b>					
	<b>Total Population</b>	<b>Bottom 90%</b>	<b>Top 10%</b>	<b>Top 5%</b>	<b>Top 1%</b>
<b>Threshold</b>		<=\$5,966	>\$5,966	>\$10,568	>\$30,050
<b>Average 2006 Spending (\$)</b>	\$2,600	\$1,045	\$16,601	\$25,399	\$60,981
<b>Share of Total 2006 Spending</b>	100%	36.2%	63.8%	48.8%	23.4%
<b>% in Category Following Year</b>			37%	28%	16%
<b>Notes:</b>	Civilian, Under-65, Non-institutionalized, Non-Medicare, Non-Medicaid. Source: 2006 MEPS.				

As Table 1 above shows:

- The top 1% of spenders accounted for more than 23% of total expenditures. Individuals in the top 1% (annual spending above \$30,000) spent an average of almost \$61,000.
- The top 5% of spenders accounted for almost half of total expenditures. Individuals in the top 5% (annual spending above \$10,568) spent an average of \$25,400.
- In contrast, the bottom 90% spent accounted for only 36% of total expenditures and spent an average of \$1,045.

Individuals with high medical expenses are usually presented with somewhat conflicting goals – protecting themselves against their high medical bills and finding access to affordable insurance. Solving these challenges involves spreading the risk associated with these individuals across sufficiently broad groups of people, providing adequate protection against expenses that could create financial hardship, and managing the care for medical conditions that can lead to catastrophic expenses. However, pricing every plan against the risk of catastrophic losses leads to high premiums and low enrollment.

Some suggest that another problem that must be addressed is “underinsurance.” Cathy Schoen (and others) define in her writings in *Health Affairs*<sup>4</sup> and elsewhere that those who are insured are considered underinsured “. . . if they experienced at least one of three indicators of financial exposure relative to income: (1) out-of-pocket medical expenses for care amounted to 10 percent of income or more; (2) among low-income adults (below 200 percent of the federal poverty level), medical expenses amounted to at least 5 percent of income; or (3) deductibles equaled or exceeded 5 percent of income.”

Our nation cannot focus only on out-of-pocket expenses, however, but must also include insurance premiums. Forcing someone to pay a very high premium for insurance just to minimize out-of-pocket expenses can create more financial hardship than a less costly plan with higher out-of-pocket exposure.

It is important to ask if insurance should provide financial protection against major medical bills or protect against most expenditures on health care. The policy debate in Washington and state capitals around the country often is confused by what is meant by “insurance.” In other sectors of the economy, insurance means protection against costs that people could not afford to pay without considerable financial difficulty, if at all. Automobile insurance is purchased to protect consumers against collision, injury, and loss of our vehicle, or homeowner’s insurance to protect against the risk of fire, theft, or other serious and expensive damage. So, generally speaking, insurance is a small loss, i.e. the payment of a premium, to avoid a large loss, possibly devastating loss.

But with health insurance, the initial premise is that insurance should pay for all medical expenses, regardless of size or financial burden, with copayments for doctors’ visits or prescription drugs of \$10 or \$15. The rest of the costs of the office visits or medicine are run through insurance, driving up the cost of the coverage. In the trade-off, accessing care for more

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<sup>4</sup> Health Affairs, “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty, June 2008.  
<http://content.healthaffairs.org/cgi/reprint/hlthaff.27.4.w298v1>

serious illnesses may be more difficult and people may be exposed to expensive copayments for larger medical bills.

Returning to the meaning of insurance as applied in other sectors of the economy would help reduce this problem. Making sure that everyone has health insurance to protect against large medical bills, providing access to routine and preventive care, and assisting those with the greatest needs and most limited resources are wise and worthwhile policy goals.

Many people may not realize that their insurance may not provide any or much catastrophic protection against out-of-pocket medical expenses. Some policies impose lifetime limits on benefits provided over the life of a covered individual, sometimes as low as \$1 million. Many policies have no annual limits on out-of-pocket expenses leaving people exposed to unlimited medical expenses. Other policies may have annual limits on some out-of-pocket expenses but not others – frequently prescription drug expenses have no limits on out-of-pocket expenses. Some policies with limits on out-of-pocket expenses do not count all out-of-pocket expenses towards satisfying such limits. For example, copays for office visits and prescriptions frequently are not counted towards satisfying a policy’s limit on out-of-pocket expenses, let alone satisfy one’s policy deductible. Often, only the coinsurance charges that apply after the policy deductible is satisfied count towards the out-of-pocket limit. But because most prescription drug coverage is provided under a separate schedule of benefits, there is no coordinated deductible or out-of-pocket limit that applies to all expenses covered by the plan. So even though an individual may satisfy their deductible or out-of-pocket limit through other medical expenses, there is no impact or limitation on out-of-pocket spending on prescription drug expenses. As more and more prescription drug coverage applies coinsurance (25%) rather than copays (\$25) for drugs in the most expensive tiers, the less protection people have against out-of-pocket expenses and the greater the risk to consumers.

Requiring all policies to provide at least an acceptable level of catastrophic protection could go a long way to protecting millions of Americans. All policies should be required to limit out-of-pocket expenses for benefits covered by the plan to no more than \$5,000 for individuals with self-only coverage and \$10,000 for individuals with family coverage, and these limits should be annually adjusted for inflation. Furthermore, all out-of-pocket expenses (including copays, deductibles, and coinsurance) for all covered benefits, including prescription drugs, must be applied towards satisfying these limits. The sliding income scale for which subsidies would be applicable is not to exceed 400 percent of federal poverty.

### **Access to Affordable Insurance**

Many of the costs incurred by individuals with high annual expenses are unpredictable and therefore are perfect candidates for spreading the risk across other insured persons. For example, some will have accidents or illnesses that cause significant health care spending in one year, but many individuals recover and return to a normal healthy life and sustained high spending often does not last more than a year. As the table above shows, of those individuals in the top 5% of spending in 2006, only 28% were still in the top 5% in the following year. This means that for 72% of individuals in the top 5% of spending in 2006, their spending in 2007 dropped below \$10,568 for the year.

But some individuals incur high cost episodes that are predictable. For example, individuals with chronic conditions are likely to have recurring episodes of care that produce larger claims costs over a particular time period. Once these individuals' conditions are known and their risks are therefore predictable, the role of the insurance carrier changes to care management. People with chronic conditions, and therefore predictably high health expenditures, can also face high health insurance premiums, or in some cases are denied coverage altogether.

Conceptually, insurance is designed to pool risks across different types of individuals – both healthy and sick. Historically, employment-based insurance has provided comparable insurance to all employees at the same premium, thus limiting adverse selection and pooling risks. However, this employment-based system results in various labor market inefficiencies such as “job-lock” whereby chronically ill individuals are reluctant to leave their employers due to the fear of not finding other insurance elsewhere.

However, individual insurance markets often work poorly for participants with known risks (usually from chronic conditions), if participation of low cost individuals cannot be maintained and cost loads for higher cost risks are not limited to some degree. The more cost load associated with higher risk individuals in the risk pool, the more cost that must be absorbed by the rest of the individuals in the pool. As premiums rise, the more low cost individuals are incented to drop out of the pool, further exacerbating the problem of pooling risk. Thus, insurers desire to separate from risk pools those individuals with predictably high costs so that they may be able to attract lower cost participants.

### **Alternative Approaches to Improving Access to Affordable Insurance for Catastrophic Costs**

Most proposals focus on address the costs of the 1-2% of the population with the most significant health care expenses each year. But it may also be important to focus on the 18-19% of the population who cannot purchase insurance at standard rates and may be subject to premium rate-ups or benefit exclusions. Greater reliance on some form of subsidies and/or insurance pooling mechanisms may be required; thus the following recommendations:

#### **Recommendation One: Cap on Out-of-Pocket Expenses**

We suggest a cap on out-of-pocket expenses which generally should be set at **no more than \$5,000 for individuals with self-only coverage and \$10,000 for individuals with family coverage, and these limits should be annually adjusted for inflation. Subsidies should be provided to assure that the cap should never go higher than 10% of family income not to exceed household income annually of 400 percent of federal poverty guidelines for a family of four or fewer, with similar caps for individuals and larger families.** In addition, all healthcare expenses, including premiums, copays, coinsurance, prescriptions drugs, should be included in reaching the cap. All insurers should be required to provide catastrophic coverage as part of a health insurance policy. This assures that health insurance – and healthcare – is affordable to the individual. Because this solution could elevate premium prices, we have offered

recommendation two below as a means of addressing catastrophic costs while simultaneously striving to lower premium costs.

### **Recommendation Two: “Back End” Subsidies to Reduce Costs to Consumers**

Under this option, the government could provide direct subsidies to insurance companies (e.g., 75% - 100% of costs) for enrollees with annual expenditures above some catastrophic level annually (e.g., \$100,000.00) that the market has difficulty covering. The subsidy would be limited to individuals with high dollar claims that make them very difficult to insure. This subsidy would lower the costs of the premium and make the insurance product available for individuals who are difficult to insure. The program could be administered by a federal agency, by a public-private partnership between the federal government and insurers, or by block grants to states which may elect to partner with insurers to manage the program.. The subsidy could be available to both individually-insured and employer-insured individuals to avoid distorting insurance choices.

Insurers would be at risk for all costs below the catastrophic level and responsible for 25% of costs above these levels, thus encouraging efficient plan design that minimizes moral hazard. The goal is to ensure equity for all purchasers with equal contributions and to provide benefits in direct accordance with costs charged to consumers. The level of the catastrophic cap would crucially affect the total budgetary cost of the subsidy. In 2005, Cogan, Hubbard, and Kessler<sup>5</sup> estimated that subsidizing 75% of claims above \$50,000 for 140,000 people would cost approximately \$3 billion annually.

Alternatively, a new federal social insurance program could be created that paid for an individual’s claims (or a percentage of one’s claims) only after a specified dollar limit was reached (e.g., \$100,000) each year. Individuals could then purchase private insurance to protect themselves against the risk for claims below the limit. This insurance could potentially be very affordable because the risk of the highest dollar claims would be covered by the catastrophic insurance program and spread across all taxpayers.

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<sup>5</sup> AEI Press/Hoover Institution, “Healthy, Wealthy and Wise – Five Steps to a Better Health Care System,” R. Glenn Hubbard, John Cogan, Daniel Kessler, 2005.