Individual Health Insurance 2009

October 2009

A Comprehensive Survey of Premiums, Availability, and Benefits

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SUMMARY

In the summer of 2009, America's Health Insurance Plans (AHIP) conducted the latest in a series of comprehensive surveys of member companies participating in the individual health insurance market. Patterned after prior surveys,[1] the new study contains detailed information on individual market premiums, application results, and benefits purchased.

The data on premiums and benefits are based on nearly 2.6 million policies in force during May or June 2009, covering approximately 4.2 million people. The data on underwriting are for more than 2 million individual applicants for coverage in calendar year 2008.

Unlike prior surveys, the 2009 results were provided in a micro-data format, which will allow in-depth distributional analysis relevant to the ongoing health reform debate. The micro-data format requires a larger investment in data preparation among responding plans, and the number of companies participating in this survey was slightly below that of AHIP's 2006-2007 survey, especially for companies specializing in HMO coverage. However, within the bounds of respondent confidentiality and the privacy rules governing this type of research, the micro-data approach could be of enormous assistance in assessing actuarial values, transition issues, and the impact of minimum benefit requirements. Subsequent reports will contain additional distributional information.

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[1] See America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (December 2007) and *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* (August 2005).

Key findings:

- Nationwide, annual premiums averaged $2,985 for single coverage and $6,328 for family plans in mid-2009. For single policies, annual premiums ranged from $1,350 for persons under age 18 to $5,755 for persons aged 60-64. For family policies, premiums ranged from $2,573 for policies covering children under age 18 to $9,952 for families headed by persons aged 60-64.

- Individual coverage was held by people of all ages. Forty (40) percent of single policies were held by people aged 45-64; 37 percent were held by people between 25 and 44 years old; and 23 percent were held by people aged 24 and under. Likewise, 53 percent of family policies were purchased by families headed by people aged 45-64; 42 percent were held by families headed by persons aged 25-44; and 5 percent were held by families headed by individuals aged 24 or younger.

- Premiums varied considerably by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences. For example, average annual premiums for single policies reported in the survey ranged from $2,606 in Iowa to $6,630 in New York.

- Approximately 87 percent of applicants undergoing medical underwriting were offered coverage. Offer rates varied from a high of 95 percent for applicants under age 18 to 71 percent for applicants aged 60-64.

- Twenty-nine (29) percent of offers in the survey were at standard premium rates; 36 percent were offered at lower (preferred) rates; and 34 percent were offered at higher-than-standard rates. Approximately 6 percent of offers included "condition waivers," i.e., coverage exceptions for specified conditions, and about 6 percent included a rate applicable to smokers.

- Standard or preferred rates were available in all age brackets. Among adults age 60 to 64 who were offered coverage, nearly three-quarters (74 percent) of offers were at standard or lower (preferred) rates.

- For PPO/POS coverage, the most common type of individual coverage in the survey, single policies had annual out-of-pocket limits under $5,000 on average, and family plans had average out-of-pocket limits of under $10,000 (for the whole family). The average lifetime maximum benefit (among plans with a maximum) was nearly $5 million.

AHIP member companies responding to the survey were asked to include only individual comprehensive or major medical coverage that is guaranteed renewable and meets the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definitions of "creditable coverage." We asked companies to report all such coverage marketed to individuals, whether as individual insurance policies or as certificates of coverage under association groups or other similar arrangements. The survey does not include Medigap, small-group major medical, large-group major medical, disability income, hospital indemnity, hospital-surgical only, short-term major medical, limited-benefit, or long-term care policies.

I. INTRODUCTION: WHY INDIVIDUAL HEALTH INSURANCE IS DIFFERENT

Nine out of ten non-elderly Americans with private health insurance receive it through their employer.[2] People generally understand how job-based coverage works, because it is the most common form of coverage.

Employer coverage is subsidized, and nearly all employers pay at least half of the premium. On average, employers pay 83 percent of the cost of single coverage and 73 percent of the cost of family coverage.[3] Therefore, employees have a strong incentive to sign up for employer coverage, regardless of their health or financial status. When nearly everybody in a firm signs up, premiums reflect the average cost of coverage for a large group of people — young and old, healthy and sick. Usually, all workers in a given workplace who choose the same coverage pay the same premium.

By contrast, the individual health insurance market is often unfamiliar and not as well understood. Because individual health insurance is not subsidized by employers, each consumer pays the entire cost, deciding whether the coverage justifies the premiums. As a result, consumers in this market tend to be very price sensitive.[4] Some consumers wait until they perceive they will need health services before purchasing coverage, resulting in higher premiums within insurance pools.

In most states, premiums for individual coverage are allowed to vary by age, which can help encourage younger people to purchase coverage. Likewise, most states allow insurers to medically underwrite new applications for coverage. This provides a powerful deterrent against waiting to purchase insurance until becoming ill, since the likelihood of illness increases with age.

Many states have high-risk pools, which allow people who cannot obtain individual health insurance for medical reasons to purchase coverage. However, premiums in high-risk pools are usually higher than the average for the individual market in the state.

In a few states, age-based premiums and medical underwriting for new policies are not allowed. "Guaranteed issue" rules require insurers to sell an individual health insurance policy without regard to a person's health, and "community rating" requires that all consumers pay the same or similar premiums without regard to age.

However, states with guaranteed issue and community rating rules tend to have higher than average premiums. Knowing that they could purchase coverage at any time, younger and healthier people may not do so in sufficient numbers to balance insurance pools. When this happens, premiums reflect the higher average costs of older and less healthy people, and people with low or moderate incomes may not be able to afford coverage.[5]

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[2] Based on data from Figure 1, page 5 of Paul Fronstin, *Sources of Health Insurance Data and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey*, Employee Benefit Research Institute, Issue Brief 334, (September 2009).

[3] Gary Claxton, et al., *Employer Health Benefits: 2009 Annual Survey*. Washington, DC: Henry J. Kaiser Family Foundation and Health Research & Educational Trust, (September 2009).

[4] See for example Susan Marquis, et al., "Subsidies and the Demand for Individual Health Insurance in California," *Health Services Research*, Vol. 39, no. 5, p. 1547-1570 (October 2004).

[5] For an analysis of guaranteed issue and community rating rules in several states, see Leigh Wachenheim, FSA, MAAA and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, AHIP/Milliman (August 2007).

II. PREMIUMS

For this survey, AHIP members with individual major medical insurance plans in force were asked to submit premium and benefit information for their individual policies as of their most recent monthly reporting period, usually May or June of 2009. The responding companies had nearly 2.6 million policies in force, covering approximately 4.2 million individuals.

Premiums by Age. People in all age brackets purchased individual insurance. Among non-elderly policyholders, 40 percent of single policies in the survey were held by persons aged 45-64; 37 percent were held by people between 25 and 44 years old; and 23 percent were held by people aged 24 and under. Of family policies in the survey, 53 percent were held by families headed by people aged 45-64; 42 percent were purchased by families headed by persons aged 25-44; and 5 percent were held by families headed by individuals aged 24 or younger (see Table 1).

Table 1. Individual Market, Distribution of Policyholders by Age, 2009

	Single		Family	
	Policies in Survey	Percent	Policies in Survey	Percent
Under 18	141,135	8%	22,185	3%
18 -24	272,090	15%	13,280	2%
25 -34	419,527	23%	103,906	13%
35 -44	262,534	14%	220,542	29%
45 -54	331,174	18%	263,258	34%
55 -64	398,441	22%	148,089	19%
All Age Groups (non-elderly)	1,824,944	100%	771,260	100%

Source: America's Health Insurance Plans.

The average annual premium in the survey for single coverage was $2,985, and for family coverage the average premium was $6,328 in 2009 (see Table 2 on page 5).[6]

For single policies, annual premiums ranged from $1,350 for a person under age 18 to $5,755 for a person aged 60-64. For family policies, annual premiums ranged from $2,573 for policies covering children under age 18 to $9,952 for families headed by persons aged 60-64. Among policies where the policyholder was under age 65, the average number of members covered under family policies in the survey was 3.03.

[6] Consistent with prior surveys, we report premiums for the non-elderly. A small number of policies in the survey were held by persons aged 65 or older. Including these policies, the average premium was $3,019 for single coverage and $6,352 for family coverage.

Table 2. Individual Market, Average Premiums by Age, 2009

	Single		Family		
	Number of Policies	Average Annual Premium	Number of Policies	Average Members per Family	Average Annual Premium
Under 18	139,652	$1,350	21,866	2.22	$2,573
18 -24	269,027	$1,429	13,112	2.26	$2,967
25 -29	265,472	$1,723	37,069	2.67	$3,756
30 -34	148,843	$2,104	65,409	3.13	$4,512
35 -39	127,972	$2,457	97,319	3.43	$5,148
40 -44	131,481	$2,888	120,383	3.50	$5,736
45 -49	156,646	$3,414	137,218	3.33	$6,404
50 -54	170,582	$4,127	123,219	2.95	$7,331
55 -59	185,791	$4,895	90,632	2.51	$8,414
60 -64	208,117	$5,755	56,071	2.21	$9,952
All Age Groups (non-elderly)	1,803,583	$2,985	762,298	3.03	$6,328

Source: America's Health Insurance Plans.

Premiums by State. Individual insurance premiums vary significantly by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences.

Table 3 (on page 6) illustrates average premiums reported in the survey by state for single and family policies. Carriers were instructed to assign each policy to the state on which its premium was based, rather than to the state in which it was originally issued. Data from states with relatively few policies reported by survey respondents are included in the national totals, but are not shown separately.

Consistent with prior surveys, Table 3 illustrates that premiums tend to be higher in New England and Middle Atlantic states with guaranteed issue and community rating rules. Of course, the data on premiums by state are more uncertain than the national averages, because the response level in many states was relatively small. However, the general patterns in this survey correspond with previous results, and continue to indicate that rating rules that allow purchase of individual coverage at any time, or that substantially compress rates between older and younger applicants, can be associated with higher average premiums.

Table 3. Individual Market, Average Annual Premiums in Selected States, 2009

State	Single	Family	Average Family Size
New York	$6,630	$13,296	2.84
Massachusetts	$5,143	$13,288	3.52
Rhode Island	$4,779	$11,107	3.26
Maine	$4,061	$7,260	2.92
Connecticut	$3,503	$8,477	3.09
New Hampshire	$3,427	$7,672	2.91
Montana	$3,305	$5,968	3.00
Nevada	$3,276	$6,119	2.89
Virginia	$3,229	$6,383	2.99
Georgia	$3,228	$7,408	3.38
Oklahoma	$3,220	$5,947	3.02
Texas	$3,208	$6,459	3.00
South Carolina	$3,204	$6,128	3.05
Florida	$3,191	$6,527	2.94
Tennessee	$3,150	$5,957	2.91
Minnesota	$2,978	$7,013	3.22
Arizona	$2,961	$5,292	3.09
Nebraska	$2,950	$5,979	3.24
California	$2,943	$6,567	2.96
Indiana	$2,930	$6,236	3.09
Pennsylvania	$2,873	$6,381	3.05
Illinois	$2,843	$6,317	3.04
Colorado	$2,777	$5,939	2.96
Kentucky	$2,740	$5,980	2.96
Missouri	$2,725	$5,657	2.97
Ohio	$2,724	$5,701	3.10
Kansas	$2,615	$5,529	3.10
North Carolina	$2,613	$5,120	3.03
Iowa	$2,606	$5,609	3.11

Source: America's Health Insurance Plans.

Premiums by Deductible Level – An Illustration Table 4 shows average premiums by several common deductible levels, for both single and family coverage. The ability to compute cross-tabulations of this kind is made possible by the complete micro-data response in this survey.

As would be expected, plans with higher deductibles usually had lower premiums. Of course, other factors, such as age, offer type, and location would also affect premiums. Future analyses will examine other cross-tabulations between types of benefits, premiums, age, and other variables.

Table 4. Average Annual Premium by Selected Deductible Levels, 2009

Single Coverage		
Deductible Level	Covered Lives	Average Premium
$0	100,786	$3,730
$500	177,911	$3,102
$1,000	186,658	$3,191
$1,500	235,536	$3,142
$2,500	333,663	$2,878
$5,000	297,518	$2,696
Family Coverage		
Deductible Level (Whole Family)	Covered Lives	Average Premium
$0	22,784	$12,686
$1,000	126,821	$7,887
$2,000	160,943	$6,986
$3,000	222,158	$7,483
$5,000	412,423	$6,251
$10,000	372,760	$5,380

Source: America's Health Insurance Plans.

III. UNDERWRITING

This component of the survey was provides detailed data on the medical underwriting process.[7] The variables were designed to measure offer rates and the types of coverage offered. We requested that carriers provide underwriting data based on the age of the primary applicant. We received data on 2,101,175 individual applicants for coverage.

We requested underwriting information on applications for individual major medical coverage received during calendar year 2008. Respondents were asked to exclude data from applications in states that require guaranteed issue in the individual market, because by definition, these states do not allow medical underwriting.[8]

Responding companies were asked to provide information on:

- the number of applicants for individual coverage;
- the number that were not processed, withdrawn by the applicant, or denied for reasons unrelated to the health of the applicant;
- the number denied for medical reasons; and
- the number for which coverage was offered.

Where coverage was offered, carriers were asked to specify the type of offer — that is, whether it was with premiums at the standard rate, higher than the standard rate, or lower than the standard, and whether there was a waiver of coverage for any medical conditions. The survey also asked about applications approved at smoker rates.

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[7] Underwriting is the process of evaluating an application for insurance. An insurance application is an offer, by the applicant to the insurer, to enter into an insurance contract. In states that allow medical underwriting, the insurer may evaluate an applicant's health status and then accept that offer, decline it, or make a counter-offer with different benefits, a different premium, or both.

[8] Policies that were issued on a guaranteed issue basis to HIPAA-qualified individuals in states that do not have a general guaranteed issue requirement were included. HIPAA, the Health Insurance Portability and Accountability Act of 1996, mandates that certain individuals who lose group health insurance be guaranteed access to individually purchased coverage. In some states, this requirement is met through a general guaranteed access requirement, or through a state-sponsored high-risk pool; in other states, certain carriers may serve as insurers of last resort for individuals who otherwise would not be able to obtain coverage. In other states, certain carriers operating in the individual health insurance market must guarantee issue policies to HIPAA-eligible individuals, even though they may underwrite other applicants for coverage.

Key Findings. For a variety of reasons, some applications for individual health insurance never make it to the medical underwriting process. For example, the individual may obtain coverage elsewhere before the application is fully processed. Individuals also may withdraw their applications or be denied coverage for reasons having nothing to do with health status, such as living outside a health plan's service area.

Overall, 16.1 percent of total applications received were either not processed, withdrawn by the applicant, or denied for non-medical reasons; the remaining 83.9 percent went through the medical underwriting process and serve as the basis for the analysis of offer rates in the survey (see Table 5).

Of the 1,763,367 individuals in the survey whose applications were medically underwritten, 87.3 percent received offers of coverage (see Table 6 on page 10).

Table 5. Individual Market, Applicants Underwritten, 2008

	Received	Processing Not Completed	Withdrawn	Non-Medical Denials	Policies Medically Underwritten
Individual Applicants	2,101,175	144,025	168,501	25,282	1,763,367
As a Percentage of Those Received					
Individual Applicants	100.0%	6.9%	8.0%	1.2%	83.9%

Source: America's Health Insurance Plans.

Table 6. Individual Market, Analysis of Offer Rates by Age, 2008

Offer Rates (Number of Applicants)			
Age of Individual Applicant	Medically Underwritten	Denials	Offered
Under 18	429,464	20,474	408,990
18 -24	249,051	25,009	224,042
25 -29	190,857	23,312	167,545
30 -34	147,959	17,292	130,667
35 -39	146,708	18,742	127,966
40 -44	140,883	19,912	120,971
45 -49	141,068	23,105	117,963
50 -54	123,686	24,287	99,399
55 -59	104,326	25,005	79,321
60 -64	89,365	26,102	63,263
All Age Groups (non-elderly)	1,763,367	223,240	1,540,127
Offer Rates (Percent of Applicants)			
Age of Individual Applicant	Medically Underwritten	Denials	Offered
Under 18	100%	4.8%	95.2%
18 -24	100%	10.0%	90.0%
25 -29	100%	12.2%	87.8%
30 -34	100%	11.7%	88.3%
35 -39	100%	12.8%	87.2%
40 -44	100%	14.1%	85.9%
45 -49	100%	16.4%	83.6%
50 -54	100%	19.6%	80.4%
55 -59	100%	24.0%	76.0%
60 -64	100%	29.2%	70.8%
All Age Groups (non-elderly)		12.7%	87.3%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Offer rates varied by age, ranging from 95 percent for people under age 18 to 71 percent for people aged 60 to 64. Likewise, 76 percent of applicants aged 55 to 59 were offered coverage, and 80 percent of applicants between the ages of 50 and 54 were offered coverage. Roughly two-thirds of individuals (66 percent) were offered the coverage they had requested at standard or lower (preferred) premium rates (see Table 7 on page 12). The remaining third (34 percent) of applicants were offered rates that were higher than standard rates.

Six (6) percent of applicants were offered coverage with "condition waivers," which stipulate exceptions from coverage for specified health conditions. However, not all individuals with condition waivers had higher premiums. Almost 2 percent of applicants had both condition waivers and higher premiums (see Table 8 on page 13).

We also asked companies to provide information on the number of offers made at "smoker rates." Companies reporting this information had higher-than-standard premiums for people who smoked, to reflect the higher costs of treating health problems associated with smoking. Among the responding companies providing data on this topic, approximately 6 percent of applicants offered coverage were charged smoker rates (see Table 9 on page 14).

Not all responding companies applied or were able to provide information on offers made with smoker rates; therefore, the number of offers analyzed in Table 9 is slightly less than the total number of offers reported in Tables 6-8.

Table 7. Individual Market, Analysis of Offers by Type and Age, 2008

Type of Offer (Number of Applicants)				
Age of Individual Applicant	Standard Premium	Higher Premium	Lower (Preferred) Premium	Number of Policies Offered
Under 18	105,444	156,629	146,917	408,990
18 -24	65,615	82,356	76,071	224,042
25 -29	52,422	55,623	59,500	167,545
30 -34	38,969	44,359	47,339	130,667
35 -39	36,658	44,396	46,912	127,966
40 -44	34,333	39,632	47,006	120,971
45 -49	35,311	37,100	45,552	117,963
50 -54	31,735	29,980	37,684	99,399
55 -59	27,078	22,317	29,926	79,321
60 -64	24,837	16,452	21,974	63,263
All Age Groups (non-elderly)	452,402	528,844	558,881	1,540,127
Type of Offer (Percent of Applicants)				
Age of Individual Applicant	Standard Premium	Higher Premium	Lower (Preferred) Premium	Percentage of Policies Offered
Under 18	25.8%	38.3%	35.9%	100%
18 -24	29.3%	36.8%	34.0%	100%
25 -29	31.3%	33.2%	35.5%	100%
30 -34	29.8%	33.9%	36.2%	100%
35 -39	28.6%	34.7%	36.7%	100%
40 -44	28.4%	32.8%	38.9%	100%
45 -49	29.9%	31.5%	38.6%	100%
50 -54	31.9%	30.2%	37.9%	100%
55 -59	34.1%	28.1%	37.7%	100%
60 -64	39.3%	26.0%	34.7%	100%
All Age Groups (non-elderly)	29.4%	34.3%	36.3%	100%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 8. Individual Market, Analysis of Condition Waivers Offered by Age, 2008

Companies Reporting Results by Age Individual Applicants Waivers (Number of Applicants)			
Age of Individual Applicant	Number of Policies Offered	Condition Waiver	Higher Premium and Condition Waiver
Under 18	408,990	10,948	7,408
18 -24	224,042	12,941	2,576
25 -29	167,545	9,882	2,007
30 -34	130,667	8,780	1,987
35 -39	127,966	9,607	2,139
40 -44	120,971	8,864	1,718
45 -49	117,963	8,684	1,618
50 -54	99,399	8,110	1,597
55 -59	79,321	7,875	1,357
60 -64	63,263	7,223	1,162
Total All Age Groups (non-elderly)	1,540,127	92,914	23,569
All Age Groups (non-elderly) Waivers (Percent of Applicants)			
Age of Individual Applicant	Policies Offered	Condition Waiver	Higher Premium and Condition Waiver
Under 18	100%	2.7%	1.8%
18 -24	100%	5.8%	1.1%
25 -29	100%	5.9%	1.2%
30 -34	100%	6.7%	1.5%
35 -39	100%	7.5%	1.7%
40 -44	100%	7.3%	1.4%
45 -49	100%	7.4%	1.4%
50 -54	100%	8.2%	1.6%
55 -59	100%	9.9%	1.7%
60 -64	100%	11.4%	1.8%
Average All Age Groups (non-elderly)	100%	6.0%	1.5%

Source: America's Health Insurance Plans.
Note: Not all responding companies reported information on condition waivers.

Table 9. Individual Market, Analysis of Smoker Rates Offered by Age, 2008

Age of Individual Applicant	Number of Policies Offered	Smoker Rate (Number of Applicants)	Smoker Rate (Percent of Applicants)
18 -24	218,105	9,859	4.5%
25 -29	161,690	10,459	6.5%
30 -34	126,655	8,463	6.7%
35 -39	124,533	8,417	6.8%
40 -44	117,625	8,232	7.0%
45 -49	114,639	8,937	7.8%
50 -54	96,519	7,038	7.3%
55 -59	76,905	4,493	5.8%
60 -64	60,768	3,312	5.5%
All Age Groups (non-elderly)	1,097,439	69,210	6.3%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding. Not all responding companies reported information on smoker rates.

IV. BENEFITS

Survey participants included detailed benefit information for all major medical policies or certificates in force during May or June 2009. As with the premium and underwriting data, benefit data were limited to guaranteed renewable plans that met the HIPAA definition of creditable coverage. Respondents were asked to identify PPO coverage or HMOs that have point-of-service (POS) options; closed-network HMO plans or exclusive provider organization (EPO) plans; health savings account (HSA) plans; and indemnity plans.[9]

For network-based health plans, we have not attempted to analyze benefit differentials between in-network and out-of-network services. In general, companies were asked to report deductibles and other cost sharing requirements based on use of in-network health care providers.

Companies provided benefit data on about 1.8 million single policies and 770,000 family policies in force. Because family policies in the survey covered an average of three individuals, this represents over 4 million covered lives.

Among survey respondents, the most prominent benefit design was PPO/POS coverage, which represented 83 percent of single policies and 73 percent of family policies in force (see Table 10). HSA coverage represented 11 percent of single plans and nearly 24 percent of family coverage. We believe that companies specializing in HMO coverage are under-represented in the 2009 survey results, and the number of policies in the HMO/EPO category is correspondingly small.

Table 10. Individual Market, Policies In Force During Study Period, 2009

	Number of Policies in Survey			
Product Type	Single		Family	
PPO/POS	1,527,795	82.8%	565,382	72.9%
HSA	207,901	11.3%	182,687	23.5%
HMO / EPO	38,053	2.1%	12,537	1.6%
Indemnity	71,229	3.9%	15,211	2.0%
All Products	1,844,978	100%	775,817	100%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

[9] The category "indemnity plans" was defined to include all products that are not based on a provider network. "HSA plans" includes all products, network-based or not, that are designed and marketed to be used in conjunction with a health savings account, whether or not an account is established at the time of sale. If an HSA plan was network-based, respondents were asked to report data on the in-network benefits.

Importantly, health insurance benefit designs are evolving rapidly, and health insurance plans are creating hybrid benefit designs that include features drawn from multiple product types. As a result, comparisons among product types can be difficult. For example, traditional HMOs are offering HSA plans with high deductibles. Likewise, HSA plans may offer network-based benefits and disease management programs. Some benefit designs labeled as PPOs are very similar to those traditionally offered by HMOs, with low co-payments and no deductibles for in-network coverage, and some HMOs with POS options have extensive benefits outside of the HMO network. Moreover, some product types may be more common in certain regions of the country. In sum, comparisons across product types should be regarded as illustrative, not definitive.

Table 11 illustrates this issue. For each policy, we asked respondents to mark whether the plan design included out-of-network benefits. Table 11 shows that a small percentage of products marked PPO, which are typically characterized by both in-network and out-of-network benefits, did not report having an out-of-network benefit. Likewise, a substantial share of products marked HMO or EPO, which are typically characterized as having closed panels of health care providers or in-network benefits only, reported having out-of-network benefits.

Table 11. Individual Market, Out-of-Network Coverage, 2009

	Percent of Policies in Survey							
	PPO/POS		HMO/EPO		HSA		Indemnity	
	Single	Family	Single	Family	Single	Family	Single	Family
Out-of-Network Coverage	96.1%	94.9%	28.3%	43.8%	97.3%	97.0%	91.3%	78.9%

Source: America's Health Insurance Plans.

For the 2009 survey, we changed the definition of deductibles and out-of-pocket maximum amounts for family coverage. In prior surveys, we asked for family deductibles and out-of-pocket maximums as "per-person" amounts. This year, we switched the definition to unified family amounts. Whole-family deductible amounts seem to be an increasingly common benefit design, and we believe the definitional change will improve accuracy of reported deductibles for family coverage.

Deductibles. Individual policies purchased from the responding companies had a wide variety of deductible levels (see Table 12 on page 17 and Table 13 on page 18). The average deductible for single PPO/POS plans purchased was approximately $2,500. Among the single PPO/POS plans purchased, nearly one-third had deductibles under $1,500; just over 40 percent had deductibles in the $1,500-$3,000 range; and just under 30 percent had deductibles of $3,000 or more.

The average deductible for single HSA products purchased was approximately $3,300 for single plans and $5,900 for family plans. For HSAs, the minimum deductible required by law for 2009 is $1,150 for single policies and $2,300 for families. By law, HSA plans have a unified family deductible — there are no separate deductibles for family members. Over 85 percent of all single HMO/EPO plans purchased had no deductible or a deductible less than $2,000.

In the 2009 survey, we asked for unified family deductibles for all types of benefit designs. As noted above, this represents a change from prior surveys, where we asked for per-person deductibles in family plans except for HSA plans (which are required by law to use whole-family deductibles).

Table 14 (on page 19) shows a complete listing of the numbers of covered lives in plans by detailed deductible level or range, by single and family coverage.

Table 12. Individual Market, Deductible Levels, 2009, PPO/POS and HSA

Percent of Policies in Survey				
	PPO/POS		HSA	
Deductible	Single	Family	Single	Family
$0 (none)	4.7%	0.2%	0.0%	0.0%
$1 -$499	2.6%	0.1%	0.0%	0.0%
$500 -$999	12.0%	4.3%	0.0%	0.0%
$1,000 -$1,499	11.7%	7.8%	5.7%	0.0%
$1,500 -$1,999	13.7%	3.6%	13.6%	0.0%
$2,000 -$2,499	6.1%	10.3%	7.2%	3.3%
$2,500 -$2,999	20.4%	3.0%	24.2%	2.0%
$3,000 -$3,999	9.2%	12.7%	16.0%	11.7%
$4,000 -$4,999	0.4%	3.8%	0.8%	10.6%
$5,000 -$5,999	16.1%	23.4%	32.3%	31.9%
$6,000 +	3.1%	30.9%	0.2%	40.5%
Total	100.0%	100.0%	100.0%	100.0%
Average	$2,456	$5,514	$3,263	$5,897

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 13. Individual Market, Deductible Levels, 2009, HMO/EPO and Indemnity

Percent of Policies in Survey				
	HMO/EPO		Indemnity	
Deductible	Single	Family	Single	Family
$0 (none)	53.7%	40.0%	13.7%	13.2%
$1 -$499	0.3%	0.3%	15.0%	6.4%
$500 -$999	2.3%	1.5%	21.6%	9.5%
$1,000 -$1,499	6.5%	6.3%	13.6%	4.7%
$1,500 -$1,999	22.6%	0.5%	3.5%	8.5%
$2,000 -$2,499	1.5%	2.6%	2.0%	7.9%
$2,500 -$2,999	4.7%	0.0%	22.7%	5.9%
$3,000 -$3,999	0.2%	22.0%	0.3%	6.7%
$4,000 -$4,999	0.0%	2.8%	0.2%	2.3%
$5,000 -$5,999	5.0%	6.3%	4.8%	21.6%
$6,000 +	3.2%	17.7%	2.5%	13.4%
Total	100.0%	100.0%	100.0%	100.0%
Average	$1,179	$2,969	$1,466	$3,566

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 14. Distribution of Covered Lives Among Survey Respondents, by Deductible Amount, 2009

	Covered Lives, Responding Plans		
Deductible Level or Range	Single	Family	Total
$0	102,248	23,377	125,625
Between $0 and $250	4,331	80	4,411
$250	18,806	742	19,548
$300	21,140	232	21,372
Between $300 and $500	6,492	2,570	9,062
$500	179,447	52,764	232,211
Between $500 and $1000	20,576	24,615	45,191
$1,000	190,132	131,651	321,783
Between $1,000 and $1,500	12,394	561	12,955
$1,500	238,158	64,188	302,346
Between $1,500 and $2,000	9,278	177	9,455
$2,000	90,846	162,056	252,902
Between $2,000 and $2,500	17,993	21,521	39,514
$2,500	335,632	59,655	395,287
Between $2,500 and $3,000	41,469	4,412	45,881
$3,000	106,799	224,959	331,758
Between $3,000 and $3,500	58	12,093	12,151
$3,500	71,419	56,423	127,842
Between $3,500 and $5,000	12,167	150,414	162,581
$5,000	302,078	416,391	718,469
Between $5,000 and $10,000	28,845	430,235	459,080
$10,000	32,036	377,254	409,290
Greater than $10,000	4,403	131,671	136,074
Total	1,846,747	2,348,041	4,194,788

Source: America's Health Insurance Plans.

Out-of-Pocket Maximum Amounts. One measure of the financial protection provided by an insurance policy is the limit placed on the consumer's annual out-of-pocket spending. Out-of-pocket limits set a maximum amount that consumers must pay in a calendar year as a result of cost-sharing provisions (e.g., deductibles, coinsurance, co-payments).

As with deductibles, in 2009, we asked for out-of-pocket limits for the whole family, not per-person amounts. This represents a change from prior surveys, where we asked for per-person amounts in family plans.

Average out-of-pocket limits for single policies purchased ranged from approximately $2,600 for HMO coverage to $4,500 for PPO/POS coverage (see Table 15 on page 21).

Traditionally, HMO plans have had low out-of-pocket cost sharing requirements, and some have not needed to use out-of-pocket maximums in their benefit designs. The averages shown in Table 15 include only plans that have an out-of-pocket maximum specified in their benefits.

For PPO/POS plans, out-of-pocket limits for single policies generally ranged from $2,500 to $7,500 and the majority of family policies had out-of-pocket limits between $3,000 and $10,000. For HSA plans, over three-quarters of the single policies chosen had out-of-pocket limits between $2,500 and $7,500.

Table 16 (on page 22) shows a complete listing of covered lives by the level or range of their out-of-pocket maximum amounts, by single and family coverage.

Table 15. Individual Market, Annual Out-of-Pocket Maximum Amounts, 2009

	Percent of Policies in Survey							
	PPO/POS		HSA		HMO/EPO		Indemnity	
	Single	Family	Single	Family	Single	Family	Single	Family
Percentage Without an Out-of-Pocket Limit	2.8%	4.4%	0.0%	0.0%	16.4%	25.4%	28.6%	40.5%
Distribution of Policies With a Limit								
Under $1,000	0.7%	0.1%	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%
$1,000 -$1,499	1.3%	0.1%	4.0%	0.0%	0.0%	0.0%	10.5%	0.0%
$1,500 -$1,999	8.8%	1.8%	12.2%	0.0%	27.8%	7.9%	1.6%	0.0%
$2,000 -$2,499	2.1%	1.7%	4.7%	1.5%	0.1%	0.0%	6.4%	9.6%
$2,500 -$2,999	10.5%	0.8%	18.2%	1.7%	0.1%	0.0%	11.1%	0.3%
$3,000 -$3,999	20.1%	9.7%	20.3%	15.0%	52.3%	18.4%	16.6%	14.2%
$4,000 -$4,999	12.5%	3.0%	3.8%	9.1%	5.5%	0.1%	17.1%	10.6%
$5,000 -$7,499	26.8%	25.9%	35.7%	42.6%	10.2%	45.7%	20.0%	17.5%
$7,500 -$9,999	14.0%	11.6%	0.3%	6.3%	3.7%	9.0%	8.9%	6.7%
$10,000 +	3.3%	45.4%	0.8%	23.6%	0.0%	18.6%	7.8%	41.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Average (policies with a limit)	$4,506	$9,290	$3,417	$6,100	$2,645	$5,091	$3,145	$4,913

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 16. Distribution of Covered Lives Among Survey Respondents, by Annual Out-of-Pocket Maximum Amount, 2009

	Covered Lives, Responding Plans		
Out-of-Pocket Maximum Level or Range	Single	Family	Total
$0	75,563	120,152	195,715
Between $0 and $1,000	9,835	1,250	11,085
$1,000	22,487	1,510	23,997
Between $1,000 and $1,500	9,726	149	9,875
$1,500	150,488	29,538	180,026
Between $1,500 and $2,000	13,273	189	13,462
$2,000	21,632	32,034	53,666
Between $2,000 and $2,500	22,377	6,072	28,449
$2,500	152,217	19,371	171,588
Between $2,500 and $3,000	44,134	2,556	46,690
$3,000	242,467	189,954	432,421
Between $3,000 and $3,500	10,308	10,914	21,222
$3,500	103,772	15,985	119,757
Between $3,500 and $4,000	5,840	28,442	34,282
$4,000	83,113	39,530	122,643
Between $4,000 and $4,500	2,857	34,940	37,797
$4,500	113,295	15,063	128,358
Between $4,500 and $5,000	2,732	13,576	16,308
$5,000	288,570	221,996	510,566
Between $5,000 and $6,000	73,911	152,970	226,881
$6,000	47,415	180,525	227,940
Between $6,000 and $7,000	14,942	17,846	32,788
$7,000	56,914	95,865	152,779
Between $7,000 and $7,500	2,223	3,623	5,846
$7,500	171,864	42,860	214,724
Between $7,500 and $8,000	49	4,152	4,201
$8,000	22,814	42,335	65,149
Between $8,000 and $9,000	8,950	6,323	15,273
$9,000	6,483	120,979	127,462
Between $9,000 and $10,000	6,113	7,154	13,267
$10,000	19,774	256,608	276,382
Between $10,000 and $15,000	14,459	251,669	266,128
$15,000	17,296	192,035	209,331
Greater than $15,000	3,677	186,648	190,325
Total	1,841,570	2,344,813	4,186,383

Source: America's Health Insurance Plans.

Lifetime Maximum Benefits. Another important measure of the level of financial protection provided by a policy is the lifetime maximum benefit. Among plans with a limit, the average lifetime maximums among the policies purchased ranged from approximately $4.8 million for PPO/POS coverage to about $5.5 million for HMO/EPO coverage (see Table 17). In the case of HMO/EPO plans, the majority (77 percent) of single policies sold had unlimited maximum benefits — as did approximately 67 percent of HMO/EPO family policies and 6 percent of PPO/POS policies.

Table 17. Individual Market, Lifetime Maximum Benefits, 2009

Percent of Policies in Survey				
	PPO/POS		HSA	
	Single	Family	Single	Family
Unlimited	6.1%	6.0%	29.0%	19.8%
Distribution of Policies with a Limit				
Under $2,000,000	0.7%	0.5%	0.4%	0.0%
$2,000,000 -$2,999,999	14.5%	17.5%	12.5%	10.1%
$3,000,000 -$3,999,999	13.3%	15.8%	34.0%	40.1%
$4,000,000 -$4,999,999	0.0%	0.0%	0.0%	0.0%
$5,000,000 -$5,999,999	50.5%	44.5%	36.1%	32.9%
$6,000,000 -$7,999,999	18.9%	17.7%	7.5%	5.4%
$8,000,000 +	2.1%	4.0%	9.5%	11.4%
Total	100.0%	100.0%	100.0%	100.0%
Average (policies with a limit)	$4,827,610	$4,884,012	$4,513,083	$4,505,533
	HMO/EPO		Indemnity	
	Single	Family	Single	Family
Unlimited	77.4%	66.8%	19.5%	25.0%
Distribution of Policies with a Limit				
Under $2,000,000	0.7%	0.0%	63.3%	43.9%
$2,000,000 -$2,999,999	8.9%	6.1%	19.0%	28.0%
$3,000,000 -$3,999,999	0.0%	0.0%	1.7%	4.3%
$4,000,000 -$4,999,999	0.0%	0.0%	0.0%	0.0%
$5,000,000 -$5,999,999	88.7%	92.7%	12.9%	17.3%
$6,000,000 -$7,999,999	0.0%	0.0%	3.1%	6.4%
$8,000,000 +	1.7%	1.1%	0.0%	0.1%
Total	100.0%	100.0%	100.0%	100.0%
Average (policies with a limit)	$5,443,759	$5,011,659	$1,895,566	$2,414,456

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Coinsurance and Co-payment Amounts. Table 18 shows coinsurance levels, which commonly ranged from 20 to 29 percent among PPO/POS plans with coinsurance requirements. Most HSA plans in the survey did not have coinsurance obligations. Where applicable, we asked companies to report coinsurance levels for in-network benefits only.

Among plans with primary care co-payments, average co-payment levels ranged from $20 to $30 (see Table 19 on page 25).

Table 18. Individual Market, Coinsurance Levels, 2009

Percent of Policies in Survey				
	PPO/POS		HSA	
Coinsurance Level	Single	Family	Single	Family
Percentage with No Coinsurance	25.9%	23.6%	88.6%	89.0%
Policies with Coinsurance				
Less than 10%	0.0%	0.0%	0.0%	0.0%
10%-19%	1.6%	2.2%	0.2%	0.1%
20% -29%	56.6%	57.8%	75.0%	74.8%
30% -39%	30.9%	31.3%	5.5%	3.5%
40% -49%	5.8%	0.3%	0.3%	0.1%
50% or more	5.1%	8.4%	19.0%	21.4%
Total	100.0%	100.0%	100.0%	100.0%
Average	25.8%	25.7%	26.6%	27.1%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 19. Individual Market, Primary Care Office Visit Co-Payments, 2009

Percent of Policies in Survey				
	PPO/POS		HMO/EPO	
	Single	Family	Single	Family
Percentage Without Primary Care Co-Payments ($0)	32.5%	41.8%	13.5%	20.4%
Among Policies with a Co-payment				
Less than $10	0.0%	0.0%	0.0%	0.0%
$10 -$14.99	0.7%	0.3%	23.6%	26.2%
$15 -$19.99	1.1%	0.9%	27.7%	15.9%
$20 -$24.99	13.6%	17.1%	11.5%	18.9%
$25 -$29.99	22.8%	21.6%	21.6%	16.1%
$30 -$39.99	43.2%	48.2%	14.3%	21.8%
$40 -$49.99	18.6%	11.7%	1.3%	1.0%
$50 or more	0.1%	0.1%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%
Average	$30	$20	$29	$21

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Among PPO/POS plans in the survey, average co-payments for specialist visits as compared to primary care co-payments were higher by $4 for single policies and $14 for family policies. Among HMO/EPO plans purchased, average co-payments for specialist visits were $4 lower for single policies and $6 higher than average co-payments for primary care visits for family policies (see Table 20 on page 26). Just under three-quarters of the PPO/POS plans selected had specialist co-payments in the range of $30 to $50.

Table 20. Individual Market, Specialist Visit Co-Payments, 2009

	Percent of Policies in Survey			
	PPO/POS		HMO/EPO	
	Single	Family	Single	Family
Percentage Without Specialist Co-Payments ($0)	41.0%	53.7%	13.4%	20.4%
	Among Policies with a Co-Payment			
Less than $10	0.0%	0.0%	0.0%	0.0%
$10 -$14.99	0.8%	0.4%	23.5%	26.2%
$15 -$19.99	0.2%	0.1%	18.7%	8.9%
$20 -$24.99	3.0%	1.2%	1.4%	1.7%
$25 -$29.99	17.6%	17.8%	21.9%	17.0%
$30 -$39.99	40.6%	49.0%	17.5%	23.1%
$40 -$49.99	32.7%	24.6%	1.3%	0.3%
$50 or more	5.1%	6.9%	15.6%	22.8%
Total	100.0%	100.0%	100.0%	100.0%
Average	$34	$34	$25	$27

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Prescription Drugs. The vast majority of individual market policyholders in the survey had drug benefits. All HMO/EPO and the majority of PPO/POS policies in this survey charged co-payments. Among single PPO/POS policies, 4 percent applied coinsurance for generic drugs and 23 percent had coinsurance for non-formulary drugs. The average coinsurance amount ranged from 20 percent for generic drugs to 41 percent for both preferred brand and non-formulary drugs (see Table 21 on page 27).

When prescription drug coverage is provided as a separate drug card benefit, it is common to provide different levels of cost sharing for different categories of drugs, such as generic drugs, brand-name drugs on a preferred list or formulary, and non-formulary drugs. Table 21 also shows that the average co-payments for both PPO/POS and HMO/EPO policies were very similar, ranging from $10 to $14 for generic drugs and between $42 and $48 for non-formulary drugs.

The majority of PPO/POS policies did not have prescription drug deductibles. Among those that did, the average deductible ranged from nearly $500 to slightly over $800 for single and family policies. More than two-thirds of single HMO/EPO policies had deductibles, and the average deductible amount was $320. (See Table 22 on page 28).

Table 21. Individual Market, Prescription Drug Benefits, Coinsurance and Co-Payments, 2009

	Percent of Policies in Survey			
	PPO/POS		HMO/EPO	
Drug 'Tier'	Single	Family	Single	Family
Generic				
No Cost Sharing	1.6%	0.5%	0.0%	0.0%
Prescription Coinsurance	3.9%	5.2%	0.0%	0.0%
Co-Payment	94.5%	94.4%	100.0%	100.0%
Total	100.0%	100.0%	100.0%	100.0%
Average Coinsurance amount	20.3%	20.2%	N/A	N/A
Average Co-Payment amount	$13	$14	$10	$11
Preferred Brand				
No Cost Sharing	0.3%	0.5%	0.0%	0.0%
Prescription Coinsurance	13.6%	14.7%	0.0%	0.0%
Co-Payment	86.0%	84.8%	100.0%	100.0%
Total	100.0%	100.0%	100.0%	100.0%
Average Coinsurance amount	40.5%	40.9%	N/A	N/A
Average Co-payment amount	$28	$28	$26	$28
Non-Formulary				
No Cost Sharing	0.4%	0.9%	0.0%	0.0%
Prescription Coinsurance	23.0%	28.0%	0.0%	0.0%
Co-Payment	76.6%	71.1%	100.0%	100.0%
Total	100.0%	100.0%	100.0%	100.0%
Average Coinsurance amount	40.5%	40.9%	N/A	N/A
Average Co-Payment amount	$44	$42	$48	$48

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 22. Individual Market, Prescription Drug Deductibles, PPO/POS, HMO/EPO and Indemnity, 2009

Percent of Policies in Survey						
	PPO/POS		HMO/EPO		Indemnity	
Deductible	Single	Family	Single	Family	Single	Family
$0 (none)	57.0%	54.1%	29.6%	40.0%	71.5%	67.8%
Among Policies with a Rx Deductible						
Average	$481	$833	$320	$1,002	$299	$428

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Emergency Room Visits. All HMO/EPOs and most PPO/POS policies in the survey had some type of cost sharing for emergency room services. The most popular cost sharing arrangement waives the policy holder's deductible in lieu of an emergency room co-payment followed by a coinsurance percentage. For HMO/EPO family policies, the average co-payment was $92 and the average coinsurance percentage was 20 percent. For PPO/POS single policies, the average co-payment was $98 and the average coinsurance percentage was 29 percent (see Table 23).

Table 23. Individual Market, Emergency Room Co-Payments/Coinsurance, 2009

Percent of Policies in Survey				
	PPO/POS		HMO/EPO	
	Single	Family	Single	Family
No Cost Sharing	8.2%	5.2%	0.0%	0.0%
Coinsurance Only	3.4%	4.8%	0.0%	0.0%
Co-Payment Only	28.9%	35.6%	34.7%	31.2%
ER Co-Payment amount, then Coinsurance	59.5%	54.4%	65.3%	68.8%
Total	100.0%	100.0%	100.0%	100.0%
Average Cost Sharing Amounts Among Those With Coinsurance, Co-Payment or Co-Payment/Coinsurance				
Average Coinsurance	25.7%	25.4%	N/A	N/A
Average Co-Payment	$66	$61	$64	$73
Average Co-Payment/Coinsurance*	$98	$94	$96	$92
Average Co-Payment/Coinsurance*	29%	27%	20%	20%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.
*Policy holders pay a coinsurance percentage after an emergency room co-payment dollar amount, deductible waived

V. METHODOLOGICAL NOTE

Although is it impossible to inspect every data point in a micro-data response of this magnitude, we believe the responses were remarkably "clean" – that is, virtually all records seem to be have been computed without error or anomaly. However, it is inevitable that some data elements may be missing or outside the usual bounds of expected responses. For example, of 4,194,788 people covered by policies for which benefit data on deductibles were reported, 105 people were reported to have deductibles that were odd numbers of dollars (an unexpected occurrence – deductibles are usually multiples of $10). For this report, we have not discarded any information from any responding company based on data cleaning or screening efforts – all tabulations in this report are based on the complete aggregated database as provided by all of the responding companies. In general, missing observations were few -- these were not treated as "zero" or "none," but were instead excluded from tabulations.

VI. ACKNOWLEDGEMENTS

This report – which updates AHIP's 2007 publication titled *Individual Health Insurance in 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* – provides the largest, most up-do-date information set on the individual health insurance market yet published. We thank the staff of AHIP member companies for taking the time to respond to our survey. The 2009 survey was designed and conducted by Hannah Yoo, with additional data analysis by Lisa Carpenter and Karen Heath of AHIP's Center for Policy and Research. For more information, please contact Jeff Lemieux, Senior Vice-President for AHIP's Center for Policy and Research, at (202)778-3200 or visit www.ahipresearch.org.

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