AHIP
Center for Policy and Research

Small Group Health Insurance in 2006

A Comprehensive Survey of Premiums, Consumer Choices, and Benefits

September, 2006

www.ahipresearch.org

CONTENTS

AHIP
Center for Policy and Research

Small Group Health Insurance in 2006: A Comprehensive Survey of Premiums, Consumer Choices, and Benefits

September 2006

SUMMARY

In early 2006, America's Health Insurance Plans (AHIP) conducted a comprehensive survey of member companies offering coverage in the small group health insurance market. Responses included premium and benefit data from more than 650,000 small groups (those with 50 or fewer employees), reflecting 4 million workers and 3.2 million dependents with coverage as of January 2006. Over 80 percent of the small groups represented had 10 or fewer employees. In total, 21 AHIP member companies provided data for the survey, including large national and regional carriers, as well as single-state and local plans. This represents by far the largest recent survey undertaken of the small group market.

Key survey results:

- In 2006, the average premium for small group health insurance was $311 per month ($3,730 per year) for single coverage and $814 per month ($9,770 annually) for family coverage.
- Within the small group market, premiums fell slightly as firm size increased. Firms with between 26 and 50 employees paid an average of $287 per month for single coverage, while firms with between 11 and 25 employees paid an average of $299 per month, and firms with 10 or fewer employees had average single premiums of $330 per month.
- Small group premiums in 2006 were slightly lower than those reported in the 2005 Kaiser Family Foundation (KFF) survey of (mostly) larger employers, despite an additional year's increase in health costs. Premiums in the KFF survey for all firms with three or more employees averaged $335 per month ($4,024 annually) for single coverage, and $907 per month ($10,880 per year) for family coverage in 2005.[1]
- Employee cost-sharing tends to be higher among small group plans. For example, the average annual deductible for PPO plans reported by the KFF survey of mostly medium-size employers (3-199 employees) in 2005 was $469, while the average deductible for single coverage in the small group market (50 or fewer employees) in AHIP's survey in 2006 was $849.
- Among small firms in large states, average premiums ranged from a high of $419 per month for single coverage ($1,097 for family coverage) in New York to a low of $246 per month for single coverage ($645 for family coverage) in Virginia. Higher-premium states included Connecticut, Massachusetts, Louisiana, New Hampshire, and Colorado. Lower-premium states included Missouri, Pennsylvania, Ohio, and California.

[1] *Employer Health Benefits: 2005*, The Kaiser Family Foundation and Health Research and Educational Trust (September 2005). The KFF survey includes some small firms and breaks the premium results into three categories: firms with 3-199 employees, firms with 200 or more employees, and the overall total (3 or more employees).

- Among employees with small group coverage, 57 percent had PPO coverage in 2006, with both in-network and out-of-network benefits. Thirty-nine (39) percent had HMO coverage, often with a point-of-service (POS) option. Approximately 4 percent of enrollees had a health savings account (HSA) benefit, with a qualifying high-deductible health plan (HDHP).

- More than 10 percent of small group enrollees had a choice of two or more benefit plans. Of workers offered an HSA plan, approximately one-third also had a choice of a PPO or HMO/POS plan. Almost half (46 percent) of enrollees in small groups chose HSA/HDHP plans when offered a choice among HSA plans and other types of health plans.

- An average PPO plan purchased by small employers included an individual deductible of $849, 18 percent coinsurance, a copayment of $21 for physician visits (in-network), and an annual out-of-pocket limit of $2,700. An average HSA plan had an individual deductible of roughly $2,220 but had relatively small cost-sharing requirements above the deductible; the average annual out-of-pocket limit for HSA plans in the small group market was approximately $2,800. An average HMO/POS plan in the small group market had copayments of about $20 for primary care office visits and about $25 for specialist visits.

Small group insurance is mostly regulated by the states. Roughly two-thirds of the states have adopted premium rating rules designed in the early 1990s by the National Association of Insurance Commissioners (NAIC), which allow rates to be adjusted for the demographics of enrollees in a group, but place limits on the magnitude of adjustments for health status, industry and other rating factors. The most common limit or "rating band" for health status is 25 percent above or below the standard rate.

Federal law requires small group health insurance to be offered on a "guaranteed-issue" basis. That is, a small business cannot be denied coverage due to the health status or illness of its employees or their dependents. In general, states with tighter limits on rating or "community rating" rules -- which do not allow rate variation based on health status or the prior claim experience of the group -- tend to have higher average premiums.

Other factors affecting premiums include state regulatory climates, high rates of illness or health risk factors among state residents, state premium taxes or assessments, the cost of hospital and physician services in individual states, and the types of products chosen and degree of deductibles or other cost-sharing purchased by the state's small businesses. One easily overlooked factor is the degree to which small group premiums reflect health care providers' uncompensated costs of caring for uninsured residents or underpayments from low reimbursement rates paid by some state Medicaid programs.

I. INTRODUCTION: THE SMALL GROUP MARKET IN CONTEXT

There are three primary markets for private major medical health insurance:

- the individually purchased health insurance market,
- the small group market, and
- the large group market.

Each market has distinct characteristics and operates under different rules. To understand the small group market, it is important to understand the other two markets as well.

The Individual Market

The individual health insurance market is regulated by the states, which set rules for benefits and premium rating.[2] Because individual coverage is not subsidized by employers, each consumer pays the full premium. As a result, consumers in the individual market tend to be very price sensitive, deciding whether the potential benefits justify the premiums.

Some consumers in the individual market wait until they perceive they will need health services before purchasing insurance, thus making it more expensive to provide coverage and increasing premiums for everyone in the market. To counter this “self-selection” phenomenon -- waiting until the need for health services before acquiring health insurance -- most states allow premiums for individual coverage to vary by age, which can help encourage younger people to purchase coverage. Likewise, most states allow insurers to medically underwrite new applications for individual coverage, which provides a powerful deterrent against waiting to purchase insurance, since the likelihood of illness increases with age.

Many states have high-risk pools, which allow people who cannot get individual health insurance because of a medical issue to purchase coverage. However, premiums in high-risk pools can be high, which can limit their usefulness for people with lower incomes, and a few high-risk pools have waiting lists or are not accepting new applicants.

In a few states, age-based premiums and medical underwriting for new policies are not allowed in the individual market. However, these states tend to have much higher-than-average premiums.[3] In those cases, younger and healthier people may not purchase coverage 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.

The Small Group Market

Small groups generally consist of firms with 2-50 employees, although some states allow self-employed people -- so-called "groups of one" -- to purchase in the small group market.

Like the individual market, the small group market is primarily governed by state law. Small group coverage generally is "fully insured" -- that is, employers purchase an insurance contract from a licensed health insurer or HMO, which takes on the full financial risk for paying claims. Operating under state law, fully insured coverage is subject to state benefit mandates, and premium taxes or assessments.

Workers' decisions to enroll in small group coverage are not as price sensitive as decisions in the individual market because employers usually pay a portion of the premium.[4] Therefore, individual self-selection is less common. However, firms with relatively few employees may be more likely to adjust their health insurance decisions based on the likelihood that certain employees will need health services. As with individual coverage, this phenomenon can cause premiums in small group insurance pools to rise.

[2] Some federal laws affect the individual market. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires guaranteed issue of individual coverage for people with prior continuous coverage in the group market.
[3] See America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* (August 2005).
[4] Of course, employers contributing to coverage for their workers make a highly price-sensitive decision when choosing to offer a health benefit plan and in selecting a health insurer.

Small group coverage is offered on a guaranteed-issue basis -- that is, medical underwriting is not used to determine whether a small firm will be offered coverage. Small group premiums are determined by state rating rules, which set the degree of required "rate compression" based on the demographic and actuarial characteristics of the group, as well as actual or predicted health status.

The most common rating rules are based on NAIC models from the early 1990s, which allow premiums to be fully adjusted for non-health-related demographic factors such as age, and also allow rates to vary within a band of plus or minus 25 percent from the standard rate based on health status or claims experience. Thus, while the health status of a firm's employees or dependents cannot be used to determine whether coverage is issued, it can be used to set rates in most states, at least to a degree.

However, some states do not allow rates to vary based on health status. The NAIC also has rating models based on "adjusted community rates," which do not allow rates to vary based on health status. They often have narrow bands on rating for other non-health-related factors as well, leading to a high degree of rate compression. A few states do not allow rate variation at all -- these states have "pure community rates." In general, average premium rates tend to be higher in community-rated states, because younger and healthier groups do not have access to lower premium rates and may choose not to acquire coverage.

The Large Group Market

“Large groups” are typically those with more than 50 employees, although the number may vary depending on state law. Many large employers choose to “self-fund,” so that they bear the ultimate risk for claims costs. These self-funded arrangements may be administered by a third party administrator (TPA) or insurance company. Other large groups provide coverage to their employees through “fully-insured” coverage from an insurance carrier.

Operating under federal law (the Employee Retirement Income Security Act or “ERISA”), self-funded group benefit plans are not subject to state benefit mandate requirements or premium rating rules.

II. PREMIUMS IN THE SMALL GROUP MARKET

Nationwide, the average premium for small group coverage in AHIP's 2006 survey was $311 per month for single coverage and $814 per month for family coverage (see Table 1). On an annual basis, this equates to $3,730 per year for single coverage and $9,770 for family coverage.[5]

TABLE 1. SMALL GROUP PREMIUMS, 2006

	Annual Premium		Monthly Premium	
	Single	Family	Single	Family
Firms with 50 or Fewer Employees	$3,730	$9,770	$311	$814

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

Premiums from more than 656,000 small groups are represented in the survey. Approximately 544,000 groups had 10 or fewer employees, with almost 1.9 million covered workers. There were just under 85,000 groups in the survey with between 11 and 25 employees; these firms had over 1.2 million covered workers. Small groups with between 26 and 50 employees were represented by almost 30,000 firms in the survey, covering more than 900,000 workers (see Table 2). Average premiums for firms of different sizes were weighted using the number of covered workers.

Premiums for Small Firms of Differing Sizes

Within the small group market, firms with larger numbers of employees had slightly lower premiums than those with fewer employees. For example, firms with between 26 and 50 employees paid an average of $287 per month for single coverage and $752 a month for family coverage (see Table 2). Firms with between 11 and 25 employees paid an average of $299 a month for single coverage and $785 for family coverage. Firms with 10 or fewer employees had average premiums of $330 a month for single coverage and $864 per month for family coverage.

In general, states require health insurers to pool premiums for all small groups. Typically, all small group rates begin with an "index rate" that is computed from a carrier's claims experience for the entire small group market in the state.

Thus, before adjustments for age, geographic area, and other rating factors, a two-employee firm would start with the same rating basis as a firm with 49 employees. However, some states allow some premium adjustment to reflect the higher administrative costs of serving the smallest firms as well as the greater likelihood of higher benefit costs in the smallest firms due to self-selection.

TABLE 2. PREMIUMS BY NUMBER OF COVERED EMPLOYEES IN SMALL GROUP PLANS, 2006

	Number of Groups in Survey	Total Covered Employees	Total Covered Lives	Average Monthly Premium - Single	Average Monthly Premium - Family
10 or Fewer Employees	544,302	1,864,783	3,393,702	$330	$864
11 - 25 Employees	84,594	1,245,100	2,256,453	$299	$785
26 - 50 Employees	27,368	924,604	1,570,999	$287	$752
All Small Groups	656,264	4,034,487	7,221,154	$311	$814

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

[5] Family premiums are estimated for a representative family of four. AHIP member plans commonly offered different premiums for families of different sizes or compositions, and this survey did not attempt to create an average family premium. For example, some plans have separately determined premiums for an adult and one child, an adult and children, or two adults and children. The estimates for family coverage reported here are based on premiums on a per-employee-per-month (PEPM) basis, which are then adjusted using information from the KFF 2005 survey to create estimates for a family of four.

TABLE 3. SMALL GROUP PREMIUMS VS. PREMIUMS FOR LARGER GROUPS		
	Monthly Premium	
	Single	Family
AHIP Small Group Survey 2006 (Firms with 50 or Fewer Employees)	$311	$814
KFF Employer Survey 2005 (Firms with 3 or More Employees)	$335	$907
KFF Employer Survey 2005 (Firms with 3-199 Employees)	$336	$882

Sources: America's Health Insurance Plans, Kaiser Family Foundation/HRET Employer Health Benefits, 2005 Annual Survey.
Note: Family premiums estimated for a family of four.

Comparison with Premiums for Larger Groups

On average, large groups appear to have higher premiums than small groups. The KFF survey for all firms with 3 or more employees -- which is heavily weighted toward groups with more than 50 workers -- reported higher average premiums in 2005 than AHIP's survey of small group plans in 2006, despite the extra year of increases in health costs. KFF reported average premiums of $335 per month for single coverage, and $907 per month for family coverage in 2005. KFF reported that premiums for the smallest size-of-firm category in their survey -- those with 3 to 199 employees -- averaged $336 per month for single coverage, and $882 a month for family coverage (see Table 3).

Intuitively, one would expect small group premiums to be higher than those of large groups, because certain administrative costs -- sales, billing, and so on -- would be spread over fewer people in small groups, and because benefit costs can be elevated by self-selection when small groups' decisions whether to purchase coverage are affected by knowledge that someone in the group is likely to need expensive care. However, benefit packages for small groups generally include higher cost-sharing levels. For example, the average deductible for PPO plans in the KFF survey of larger firms was $469, while the average individual deductible for small groups in AHIP's survey was $849 (see Table 4). The higher average deductible presumably results in lower premiums. Moreover, premiums for small employers are less likely to reflect extra costs from retiree health insurance programs, which are not commonly offered by small firms.

TABLE 4. AVERAGE ANNUAL DEDUCTIBLE FOR PPO PLANS, SINGLE COVERAGE		
	AHIP 2006 (Firms Size 50 or Fewer)	KFF 2005 (Firm Size 3-199)
Average Deductible	$849	$469

Sources: America's Health Insurance Plans, Kaiser Family Foundation/HRET Employer Health Benefits, 2005 Annual Survey.
Note: Both sources include "zero deductible" PPO plans in the average.

Premiums by State

Table 5 (on page 9) shows how premium rates vary by state for all small group plans. States with survey responses representing fewer than 3,000 covered lives are not shown separately in Table 5 or the premium tables that follow; however, data from those states are included in the national totals.

Among states with large populations, California, Pennsylvania, Arizona, Missouri, Virginia and Georgia had relatively low premium rates. New York, Louisiana, Massachusetts, Colorado, Florida, New Jersey, and Connecticut were large-population states with relatively high premium rates.

State-by-state variations in premiums can be attributed to several factors, including demographics, the variety of health insurance plans available in the market and the types of products chosen, the cost of health care services in the state, premium taxes and assessments, and the degree to which private premiums reflect the unpaid health costs of the uninsured or low payment rates in state Medicaid programs.

Two factors directly related to small group market regulation can have an impact on average premium rates. First, states that do not allow rates to vary by health status generally have higher average rates. In these states, small firms with relatively healthy employees are not eligible for any health-status related premium reductions, and they may choose to forgo coverage. As a result, average rates for firms remaining in the small group pool rise.

Second, states that allow self-employed individuals, or so-called "groups of one" to purchase coverage in the small group market also may see increases in average rates. In these states, self-employed individuals may delay purchasing insurance until they need health care services and can then obtain coverage on a guaranteed-issue basis at rates regulated under the state's small group rules. However, this phenomenon may be limited when pre-existing condition waiting periods are used for newly issued policies.

Table 6 (on page 10) shows premium rates by state for firms with between 26 and 50 employees; Table 7 (on page 11) shows premiums by state for firms with 11-25 employees, and Table 8 (on page 12) shows premiums for firms with 10 or fewer employees.

TABLE 5. PREMIUMS BY STATE, ALL SMALL GROUPS, 2006		
States	Average Monthly Premium Single	Average Monthly Premium Family
Alaska	$436	$1,141
New York	$419	$1,097
Connecticut	$404	$1,059
West Virginia	$401	$1,051
Massachusetts	$392	$1,027
New Hampshire	$377	$989
Louisiana	$373	$978
Wyoming	$369	$966
Colorado	$362	$950
Rhode Island	$352	$923
Nevada	$349	$914
Utah	$349	$913
Nebraska	$347	$910
Florida	$345	$904
New Jersey	$342	$896
Maine	$341	$893
Texas	$338	$886
Maryland	$330	$864
Wisconsin	$327	$857
New Mexico	$325	$852
North Carolina	$325	$852
Minnesota	$324	$849
Montana	$320	$838
Illinois	$317	$832
Oklahoma	$316	$827
Michigan	$315	$826
Indiana	$314	$823
United States	**$311**	**$814**
South Dakota	$310	$811
Mississippi	$307	$803
Kentucky	$303	$794
South Carolina	$300	$786
Georgia	$299	$783
Kansas	$299	$785
Alabama	$297	$777
Tennessee	$297	$779
California	$296	$775
Ohio	$296	$776
Pennsylvania	$294	$770
Missouri	$292	$765
Iowa	$285	$747
Arizona	$281	$736
Virginia	$246	$645
Washington	$245	$643
North Dakota	$234	$612

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

TABLE 6. PREMIUMS BY STATE, GROUPS WITH 26 TO 50 EMPLOYEES, 2006		
States	Average Monthly Premium Single	Average Monthly Premium Family
New York	$422	$1,107
Connecticut	$393	$1,030
Louisiana	$354	$928
New Hampshire	$353	$925
Rhode Island	$353	$924
New Jersey	$343	$898
Colorado	$342	$896
Minnesota	$332	$870
Utah	$329	$862
Nebraska	$322	$843
Maine	$316	$828
Wisconsin	$314	$823
Texas	$313	$821
Nevada	$311	$815
Florida	$310	$813
Maryland	$303	$794
Indiana	$301	$788
Oklahoma	$293	$766
Michigan	$292	$765
Pennsylvania	$291	$763
Illinois	$290	$761
United States	**$287**	**$752**
North Carolina	$286	$749
Ohio	$283	$741
Kentucky	$281	$735
Mississippi	$281	$737
Tennessee	$279	$730
Georgia	$278	$727
Iowa	$278	$729
California	$277	$725
Missouri	$275	$721
Kansas	$268	$702
South Carolina	$265	$694
Arizona	$259	$678
Virginia	$240	$629

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

TABLE 7. PREMIUMS BY STATE, GROUPS WITH 11 TO 25 EMPLOYEES, 2006		
States	Average Monthly Premium Single	Average Monthly Premium Family
New York	$415	$1,088
Connecticut	$384	$1,007
New Hampshire	$356	$933
Massachusetts	$351	$919
Rhode Island	$349	$914
Colorado	$344	$901
Utah	$341	$894
New Jersey	$340	$890
Nevada	$331	$868
Louisiana	$329	$862
Nebraska	$328	$858
Wisconsin	$324	$849
Minnesota	$322	$844
Michigan	$316	$828
Texas	$314	$822
New Mexico	$312	$816
Maryland	$311	$815
Maine	$310	$811
Florida	$309	$811
Indiana	$299	$782
United States	**$299**	**$785**
Illinois	$298	$782
North Carolina	$293	$769
Oklahoma	$293	$769
Kansas	$291	$763
Pennsylvania	$291	$763
Alabama	$287	$753
Georgia	$286	$750
Kentucky	$286	$749
California	$285	$748
Tennessee	$285	$747
Missouri	$284	$743
Mississippi	$280	$733
Ohio	$278	$729
South Carolina	$277	$727
Iowa	$269	$704
Arizona	$264	$691
Virginia	$248	$649

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

TABLE 8. PREMIUMS BY STATE, GROUPS WITH 10 OR FEWER EMPLOYEES, 2006		
States	Average Monthly Premium Single	Average Monthly Premium Family
Louisiana	$437	$1,146
Connecticut	$424	$1,110
New York	$419	$1,099
Massachusetts	$404	$1,058
New Hampshire	$399	$1,045
Nebraska	$386	$1,012
Nevada	$383	$1,004
North Carolina	$382	$1,002
Florida	$381	$999
Colorado	$379	$993
Utah	$377	$987
Texas	$376	$985
Maine	$364	$954
Mississippi	$358	$937
Rhode Island	$355	$929
Maryland	$354	$926
New Mexico	$353	$924
Oklahoma	$349	$913
Kansas	$344	$901
New Jersey	$343	$898
South Carolina	$341	$894
Wisconsin	$338	$886
Indiana	$337	$884
Illinois	$334	$875
Michigan	$330	$863
United States	**$330**	**$864**
Georgia	$329	$863
Arizona	$326	$855
Tennessee	$326	$853
Kentucky	$324	$850
Minnesota	$320	$840
Ohio	$317	$831
California	$309	$810
Missouri	$309	$811
Alabama	$302	$792
Iowa	$302	$792
Pennsylvania	$298	$780
Virginia	$248	$651

Source: America's Health Insurance Plans.
Note: Family premiums estimated for a family of four.

III. PRODUCTS PURCHASED BY SMALL GROUPS

AHIP members reported in detail on the products and benefits purchased by most of the small group plans in the survey. Thus, the overall product and benefit data represent a universe of small groups virtually identical to that reflected in the premium data presented in the previous section, and include information representing the coverage of almost 3.4 million workers.

AHIP asked survey respondents to provide separate responses for indemnity plans, PPO coverage, HSA-eligible high-deductible health plans, HMOs (including those with POS options), and health reimbursement arrangement (HRA) plans. Data were weighted by the number of covered workers. Respondents were asked to include data on policies or certificates in-force as of January 2006, and to provide data only for major medical plans that meet the HIPAA definition of creditable coverage.

The term "indemnity plans" was defined to include all products that are not based on a provider network. "HSA plans" include all products, network-based or not, that are designed and marketed to be used in conjunction with health savings accounts, regardless of whether accounts have actually been established. If an HSA plan included a provider network, respondents were asked to report based on the in-network benefits.

The survey did not attempt to distinguish between separate or combined deductibles for in-network and out-of-network services. In general, deductibles were reported as if enrollees had used only in-network providers. Average values for other types of cost-sharing -- such as coinsurance levels or copayments -- were generally reported only for plans that reported having that type of cost-sharing. For example, if half of all small group plans used physician copayments and half did not, the results for average physician copayments below are based on data only from those plans that had them. Therefore, in this case AHIP would not register "no-copayments" as a "zero" for the purpose of calculating average copayment rates.

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 between product types can be more difficult. For example, traditional HMOs are offering HSA plans with high deductibles. Likewise, HSA/HDHP plans may offer network-based benefits and disease management programs. Some benefit designs labeled as PPO are very similar to those traditionally offered by HMOs, with low copayments 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.

Product Choices

The most common health insurance product among small groups represented in the survey was PPO coverage, which represented approximately 57 percent of the policies in-force, or more than 1.9 million employees (see Table 9). Thirty-nine percent of workers (approximately 1.3 million) had HMO/POS coverage; 4 percent of employees (127,000) had HSA/HDHP coverage.

TABLE 9. PRODUCT TYPE, BY NUMBER OF COVERED EMPLOYEES SMALL GROUP MARKET, 2006

	Number of Covered Employees in Survey	Distribution of Covered Employees
PPO	1,925,557	57%
HMO/POS	1,300,439	39%
HSA/HDHP	127,256	4%
Indemnity	16,332	*
HRA	1,600	*
Total	3,371,184	100%

*less than 0.5%
Source: America's Health Insurance Plans.

Roughly 16,000 employees had indemnity coverage and 1,600 employees had HRA coverage. Because these enrollment levels were too low to form the basis for reliable conclusions, these product types are not included in the discussion below.

Comparison of Product Types with Larger Groups

Small groups may have a slightly greater willingness than large groups to accept limitations on provider choice in exchange for lower premiums. A comparison of AHIP's survey data on small groups with the KFF survey of (mostly) medium-sized and large group plans suggests that small group employees are slightly less likely to have PPO coverage, and slightly more likely to have HMO or HMO/POS plans (see Table 10).

TABLE 10. DISTRIBUTION OF COVERED EMPLOYEES BY PRODUCT TYPE, AHIP VS. KFF

	AHIP 2006 (50 or Fewer Workers)	KFF 2005 (50-199 Workers)	KFF 2005 (200 Workers or More)
PPO	57%	65%	63%
HMO/POS	39%	33%	35%
HSA/HDHP	4%	N/A	N/A
Indemnity/ Conventional	*	3%	3%

*less than 0.5%
Source: America's Health Insurance Plans.

Premiums for Different Products

Both HMO and HSA plans in the small group market tended to have lower premiums than the average for the market, while POS plans had higher premiums. PPO plans, which comprise a large share of the market, have premiums roughly equal to the overall average (see Table 11).

TABLE 11. SMALL GROUP PREMIUMS BY TYPE OF PRODUCT PURCHASED

Type of Plan	Single	Family
HMO	$289	$756
POS	$355	$930
HSA	$264	$692
PPO	$310	$812
All Groups	$311	$814

Source: America's Health Insurance Plans.

IV. CONSUMER CHOICES

A subset of firms in the AHIP survey responded in a format that allows distributional tabulations. Ten AHIP member firms responded in this format, representing 1.3 million covered workers, or about one-third of the total response. This subset of responding firms included local and national plans with a large variety of health plan offerings in a total of 49 states. Data from this subset of respondents were controlled to aggregated totals from the entire survey universe of 21 AHIP member companies.

According to the survey, the proportion of small firms offering a choice among products or benefit packages is relatively low (see Table 12). Based on data from the subset of AHIP member companies from which detailed firm-by-firm benefit data are available, 87 percent of employees in firms with fewer than 50 workers were offered one plan; 13 percent were offered two plans; and only a very small fraction were offered three or more benefit plans.

TABLE 12. PROBABILITY OF A CHOICE OF PLANS OR BENEFIT PACKAGES SMALL GROUP MARKET, 2006

	Small Groups (50 or fewer workers)
One Plan	87%
Two Plans	13%
Three or More Plans	*

*less than 0.5%
Source: America's Health Insurance Plans

However, among small groups offering HSA/HDHP coverage, approximately one-third offered employees additional coverage options (see Table 13). Among firms with 10 or fewer workers, 16 percent of workers offered an HSA/HDHP plan were also offered different health plans. By contrast, among firms with between 11 and 25 employees, 63 percent of employees offered HSA/HDHP coverage had alternative coverage options, and among groups with between 26 and 50 workers, nearly 80 percent of workers offered HSA/HDHP coverage had a choice of plan.

TABLE 13. CHOICES AVAILABLE TO EMPLOYEES WITH HSA/HDHP PLANS SMALL GROUP MARKET, 2006

	HSA/HDHP only option	HSA/HDHP with other options
1-10 Employees	84%	16%
11-25 Employees	37%	63%
26-50 Employees	22%	78%
All Small Groups	68%	32%

Source: America's Health Insurance Plans.

Among small groups offering HSA/HDHP coverage as an option, a PPO plan was also available nearly 80 percent of the time, and an HMO or POS plan was available about one-fifth of the time (see Table 14)

TABLE 14. OTHER PLANS AVAILABLE TO HSA/HDHP ENROLLEES WITH A CHOICE OF PLANS SMALL GROUP MARKET, 2006

HMO & POS	21%
PPO	79%
Total	100%

Source: America's Health Insurance Plans.

A relatively high percentage of people offered HSA/HDHP coverage chose it. Table 15 shows that roughly 45 percent of workers given an option of HSA/HDHP or other coverage chose the HSA/HDHP plan. This result was the same for firms with 10 or fewer workers (47 percent), 11-25 workers (47 percent), and 26-50 workers (44 percent).

TABLE 15. PERCENTAGE OF SMALL GROUP EMPLOYEES WITH A CHOICE OF HSA/HDHP PLAN OR OTHER PLAN THAT CHOOSE HSA/HDHP COVERAGE, 2006

1-10 Employees	47%
11-25 Employees	47%
26-50 Employees	44%
Average	46%

Source: America's Health Insurance Plans.

HSA/HDHP plans are required to have annual limits on enrollees' overall out-of-pocket costs -- in some cases lower limits than those of PPOs. Table 16 compares the out-of-pocket limits for HSA/HDHP plans and PPO plans with varying deductibles.

TABLE 16. COMPARISON OF AVERAGE ANNUAL OUT-OF-POCKET LIMITS (HSA PLANS VS. PPO PLANS) SMALL GROUP MARKET, 2006

Annual Deductible	HSA/HDHP	PPO
$0 (no deductible)	-	$2,048
$1-$249	-	$1,057
$250-$499	-	$1,754
$500-$749	-	$2,310
$750-$999	-	$3,011
$1,000-$1,499	$1,406	$2,370
$1,500-$1,999	$2,232	$3,977
$2,000+	$3,442	$4,049
Overall	$2,794	$2,743

Source: America's Health Insurance Plans.

V. DETAILED BENEFIT INFORMATION

Benefits purchased by small groups are summarized in Table 17 and are explored in more detail in the tables that follow.

The average deductible for single coverage was approximately $849 for PPO plans, $2,200 for HSA/HDHP plans, and $470 for HMO/POS plans (see Table 18 on page 18). For HMO/POS plans, this average reflects only those plans that have deductibles. All HSA/HDHP plans have deductibles, and 94 percent of PPO plans in the survey had deductibles. However, only 40 percent of HMO/POS plans had deductibles.

Once the deductible has been met, many policies require individuals to pay a percentage of their costs -- called coinsurance -- until the annual out-of-pocket limit is reached.

Most PPO plans in the small group market required enrollees to pay a percentage of health costs over the deductible, with coinsurance rates averaging 17 percent (see Table 19 on page 18). By contrast, three-quarters of HSA/HDHP plans and two-thirds of HMO/POS plans did not include coinsurance. For HMOs, this is because copayments (often $20 or $25 per service) are charged instead. For HSA/HDHP plans, the deductible may be viewed as the main form of enrollee cost-sharing, and once the deductible is met, cost-sharing requirements are small.

Copayments are a common form of cost-sharing among network-based health insurance plans. All HMO/POS plans and 93 percent of PPO plans in the small group market charged copayments for primary care office visits (see Table 20 on page 19). Copayments averaged approximately $20 per visit in 2006.

Likewise, most PPO and HMO/POS plans required co-payments for office visits to specialists. Average copayments for specialists were slightly higher than average copayments for primary care services. For example, copayments for specialty care averaged $25 for HMO/POS coverage, while copayments for primary care averaged $19 (see Table 21 on page 19).

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 on how much consumers must pay in a calendar year as a result of deductibles, copayments, or other cost-sharing provisions.

TABLE 17. BENEFIT CHARACTERISTICS, BY PRODUCT – SMALL GROUP MARKET, 2006

	HSA/HDHP	PPO	HMO/POS
Average Deductible (Single)	$2,222	$849	$471
Percent with a Deductible	100%	94%	40%
Average Annual Out-of-Pocket Maximum	$2,794	$2,743	$1,763
Percent with an Out-of-Pocket Maximum	100%	94%	80%
Average Coinsurance Level	17%	17%	13%
Percent with Coinsurance	26%	82%	31%
Average Lifetime Maximum Benefit	$4,539,837	$4,723,128	$2,679,073
Percent with a Lifetime Maximum	46%	38%	17%
Average Primary Care Office Visit Copayment	N/A	$21	$19
Percent with Primary Care Copayment	21%	93%	100%
Average Specialist Visit Copayment	N/A	$23	$25
Percent with Specialist Copayment	5%	81%	89%

Source: America's Health Insurance Plans.
Note: The average deductible for HMO/POS plans was calculated among plans with a deductible, thereby excluding those with no deductible or those which reported a deductible of $0.

TABLE 18. DISTRIBUTION OF POLICIES BY DEDUCTIBLE LEVEL – SMALL GROUP MARKET, 2006			
	Percent of Policies in Survey		
Deductible Levels	HSA/HDHP	PPO	HMO/POS
$0 (no deductible)	0%	6%	60%
$1 - $249	0%	1%	1%
$250 - $499	0%	23%	5%
$450 - $749	0%	22%	17%
$750 - $999	0%	2%	1%
$1,000 - $1,499	22%	27%	9%
$1,500 - $1,999	6%	6%	5%
$2,000 +	72%	13%	2%
Lowest Offered	$1,050	$0	$0
Highest Offered	$5,100	$10,000	$7,000
Average Purchased	$2,222	$849	$471

Source: America's Health Insurance Plans.
Note: The average deductible for HMO/POS plans was calculated excluding those with no deductibles.

TABLE 19. COINSURANCE LEVELS – SMALL GROUP MARKET, 2006			
	Percent of Policies in Survey		
Coinsurance Level	HSA/HDHP	PPO	HMO/POS
No Coinsurance	74%	18%	69%
Less than 10%	0%	0%	0%
10% - 19%	6%	19%	4%
20% - 29%	20%	50%	20%
30% - 39%	*	9%	5%
40% - 49%	*	4%	1%
50% or more	0%	*	1%
Lowest Offered	0%	0%	0%
Highest Offered	50%	50%	50%
Average Purchased	17%	17%	13%

*less than 0.5%.
Source: America's Health Insurance Plans

TABLE 20. PRIMARY CARE OFFICE VISIT COPAYMENTS -- SMALL GROUP MARKET, 2006		
	PPO	HMO/POS
Percentage of Policies With a Primary Care Copayment	93%	100%
Copayment Level	Percent of Policies in Survey	
Less than $10	*	1%
$10 - $14.99	6%	18%
$15 - $19.99	12%	25%
$20 - $24.99	40%	31%
$25 - $29.99	18%	13%
$30 or more	24%	12%
Lowest Offered	$0	$0
Highest Offered	$50	$50
Average Purchased	$21	$19

*less than 0.5%
Source: America's Health Insurance Plans.

TABLE 21. SPECIALIST OFFICE VISIT COPAYMENTS -- SMALL GROUP MARKET, 2006		
	PPO	HMO/POS
Percentage of Policies With a Specialist Copayment	81%	89%
Copayment Level	Percent of Policies in Survey	
Less than $10	*	11%
$10 - $14.99	4%	6%
$15 - $19.99	13%	8%
$20 - $24.99	42%	17%
$25 - $29.99	19%	15%
$30 or more	22%	43%
Lowest Offered	$0	$0
Highest Offered	$80	$80
Average Purchased	$23	$25

*less than 0.5%
Source: America's Health Insurance Plans.

In 2006, most small group plans had explicit limits on consumers' annual out-of-pocket costs. HSA/HDHP plans are required by law to have limits; 94 percent of PPO plans and 80 percent of HMO/POS plans in the small group market have limits (see Table 22). Average out-of-pocket limits ranged from approximately $2,700-$2,800 for HSA/HDHP and PPO plans. Among the HMO/POS plans with limits on annual out-of-pocket costs, the average limit was approximately $1,700. HMO plans with low copayments may not specify limits on enrollees' out-of-pocket costs, because out-of-pocket payments in those plans would be relatively low even for patients with severe illnesses.

Another important measure of the financial protection provided by a policy is the lifetime maximum benefit. Most plans in the small group market had no lifetime limits on benefits. For example, 83 percent of HMO/POS plans in the survey had no lifetime limits; 62 percent of PPO plans and 54 percent of HSA/HDHP plans also did not have a lifetime maximum (see Table 23 on page 21). Among small group plans with lifetime limits on benefits, the average limit ranged from $2.7 million for HMO/POS plans to $4.7 million for PPO plans.

By design, HSA/HDHP products have more up-front cost-sharing than most other plans in the market. Although many HSA/HDHP products cover preventive services without regard to the deductible, they are not generally intended to cover most routine medical expenses -- that is the purpose of the health savings account itself. But, based on the two key measures of catastrophic coverage -- the annual out-of-pocket limit and the lifetime maximum benefit -- they provide as much protection against the cost of a truly catastrophic illness or injury as most other plans in the market.

Most small group plans had tiered copayments for prescription drugs. Copayments were lowest for generic drugs, higher for brand-name drugs on health plan formularies (often called "preferred brand-name drugs"), and highest for brand-name drugs not on plan formularies (often called "non-preferred drugs"). In the small group market, average copayments for generic drugs ranged from $10-$13; average copayments for preferred brand-name drugs ranged from $26-$29; and copayments for non-preferred brand-name drugs averaged $40-$45 (see Table 24 on page 21).

Small group insurers were asked whether they offered a variety of specific benefits within their benefit packages and how many employees chose them. The results, shown in Table 25 (on page 22), are weighted by the number of employees with each benefit. The values for PPO and HMO/POS plans are based on in-network benefits.

TABLE 22. ANNUAL OUT-OF-POCKET LIMITS – SMALL GROUP MARKET, 2006

	HSA/HDHP	PPO	HMO/POS
Percentage With an Out-of-Pocket Limit	100%	94%	80%
Distribution of Policies With a Limit	Percent of Policies in Survey		
< $500	0%	3%	12%
$500 - $999	0%	1%	5%
$1,000 - $1,499	17%	13%	5%
$1,500 - $1,999	5%	9%	23%
$2,000 - $2,999	39%	32%	27%
$3,000 +	39%	42%	28%
Lowest Offered	$1,050	$250	$200
Highest Offered	$10,000	$15,150	$17,000
Average Purchased	$2,794	$2,743	$1,763

Source: America's Health Insurance Plans.

TABLE 23. LIFETIME MAXIMUM BENEFITS – SMALL GROUP MARKET, 2006			
	HSA/HDHP	PPO	HMO/POS
Policies with Lifetime Limits	46%	38%	17%
Distribution of Policies With Limits	Percent of Policies in Survey		
< $1,000,000	0%	0%	2%
$1,000,000 - $1,999,999	*	*	26%
$2,000,000 - $2,999,999	14%	7%	40%
$3,000,000 - $4,999,999	1%	5%	2%
$5,000,000 +	85%	88%	30%
Lowest Offered	$1,000,000	$1,000,000	$500,000
Highest Offered	$5,000,000	$5,000,000	$5,000,000
Average Purchased	$4,539,837	$4,723,128	$2,679,073

*less than 0.5%.
Source: America's Health Insurance Plans.

TABLE 24. PRESCRIPTION DRUG COPAYMENTS – SMALL GROUP MARKET, 2006			
	Percent of Policies in Survey		
Prescription Drug Copayment Information	HSA/HDHP	PPO	HMO/POS
Percentage of Policies With Generic Copayment	76%	95%	99%
Lowest Offered	$0	$0	$0
Highest Offered	$20	$50	$50
Average Purchased	$10	$11	$13
Percentage of Policies with Preferred Brand-Name Copayment	72%	94%	99%
Lowest Offered	$0	$0	$0
Highest Offered	$40	$60	$50
Average Purchased	$29	$28	$26
Percentage of Policies with Non-preferred Brand-name Copayment	75%	93%	99%
Lowest Offered	$0	$0	$0
Highest Offered	$60	$100	$100
Average Purchased	$45	$42	$40

Source: America's Health Insurance Plans.

TABLE 25. SPECIFIC BENEFITS – SMALL GROUP MARKET, 2006			
	Percentage of Covered Employees in Survey With Benefit		
	HSA/HDHP	PPO	HMO/POS
Adult Physicals	100%	73%	100%
Outpatient Mental Health	100%	84%	97%
Inpatient Mental Health	100%	85%	91%
Annual OB/GYN Visit	97%	100%	100%
Prenatal Care	96%	100%	100%
Oral Contraceptives	93%	95%	98%
Well-Baby Care	100%	100%	100%
Chiropractic Care	96%	93%	75%
Source: America's Health Insurance Plans.			

VI. SURVEY METHODOLOGY

All AHIP members with blocks of small group health insurance in-force were invited to participate in the survey. Respondents were asked to include only fully insured major medical coverage that meets the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of guaranteed renewable and "creditable coverage." In order to ensure consistency of the data across states, they were asked to include only policies sold to groups with 50 or fewer employees, even if their state's definition of "small group" included firms with more than 50 employees. Policies sold to self-employed workers were included only when they were regulated by the state as part of the small group market. The survey did not include stop-loss insurance, individual and large group major medical, disability income, hospital indemnity, Medigap, hospital-surgical only, limited benefit, or long term care policies. Reporting was based on policies or certificates in-force during January 2006.

The survey collected information on both premiums and benefits. Survey participants were given two options for submitting data: a "micro-data" format in which data were provided at the case level, and a more traditional aggregated format.

Respondents submitting data in the traditional aggregated format were asked to complete two survey forms: one for premium data, and one for benefit data. The premium data form requested average single premiums and per employee premiums by group size and by state. The group size categories were 10 or fewer employees; 11 to 25 employees; and 26 to 50 employees. For each group size/state cell, respondents were asked to report the number of groups, covered employees, and covered individuals.

The aggregated benefit data form requested detailed information on deductibles, coinsurance, out-of-pocket limits, lifetime maximum benefits, physician copayments, prescription drug coverage, and certain ancillary benefits. Respondents were asked to provide information on both the range of benefit features offered and the benefits actually purchased by small employers. Benefits for indemnity plans, HSA/HDHP coverage, PPOs and HMO/POS plans were reported separately. Unless otherwise specified, all values (e.g., deductibles and benefit maximums) reflect the benefit levels applicable to overall major medical expense benefits. For products based on provider networks, respondents were asked to report based on the benefit provisions for in-network services.

Respondents submitting data in the micro-data format were asked to provide two separate data files: one for premium data and one for benefit data. Premium information was reported at the "case" level -- one plan of benefits provided to a single small firm. If an employer offered employees the choice of two benefit plans, two cases were reported. Respondents were asked to assign a unique identifier to each case and to each firm. This made it possible to aggregate cases up to the firm or case level. Unless otherwise stated, all group counts are at the firm level. The premium data included state, number of covered employees, number of covered individuals, average premium per employee, and total premium for the case. In general, information from the subset of cases reported in micro-data format were adjusted to control for overall totals or averages from the full dataset, reported in both micro-data and aggregated format.

For each case in the premium file, respondents were also asked to include a code for each case that identified its benefits plan. The benefit file included a record for each benefits plan and was linked to the premium file using the same benefit code. The benefit file captured a limited number of plan features, including the annual deductible, coinsurance percentage, annual out-of-pocket limit, lifetime maximum benefit, physician copayments, and prescription drug copayments. Respondents were asked to categorize benefit plans by product type, using the following definitions:

Type Code	Definition of Product Type
HSA/HDHP	A health savings account (HSA) product; any high-deductible health plan (HDHP) product that is designed and marketed to be used in conjunction with a health savings account, whether or not an account is actually established at the time of sale. Archer medical savings account (MSA) products are included in reporting for HSA products.
HRA	A health reimbursement arrangement (HRA) product; any high-deductible health plan product that is designed and marketed to be used in conjunction with a health reimbursement arrangement.
PPO	A preferred provider organization (PPO) product; network-based plans that provide some level of coverage for services received from non-network providers, which do not require enrollment with a primary care gatekeeper physician or specialist referrals.
HMO	A health maintenance organization (HMO) product; any network-based plan that is licensed and regulated by the state as a health maintenance organization.
POS	A point-of-service (POS) HMO product; network-based plans that provide some level of coverage for services received from non-network providers, which require enrollment with a primary care gatekeeper and are licensed as a health maintenance organization. Note that this category was combined with HMO plans for companies reporting in the aggregated data format.
IND	An indemnity product; any product that is not based on a provider network. Respondents were instructed to report indemnity products designed to be sold in conjunction with an HSA as HSA/HDHP products.

The procedures followed in conducting and publishing the survey were designed to protect the confidentiality of individual companies' data, and AHIP made several commitments to survey respondents. No individual company's data or sensitive data would be disclosed to any third party outside of AHIP, other than to the consulting actuary assisting with the project. All responses would be aggregated for reporting purposes to ensure a sufficient response for each reported statistic so that each statistic included in the final report represents a response that cannot be attributed to a single respondent.

The micro-data format provides some significant benefits for the analysis, making it possible to explore the relationships between premiums and specific plan design features. To make it easier for participants to use the micro-data format, we intentionally limited the number of data items requested. In particular, we requested only the average monthly premium per employee, and not the average premium for single coverage.

We did ask for both the per-employee and single coverage premiums in the aggregated data format, which provided a credible basis for estimating the relationship between single and average per-employee premiums. Using data from respondents submitting aggregated data that included both the single and per covered employee premiums, we calculated the average ratio between the two. The calculation was also performed separately for each of the three group size categories. These ratios were then applied to the average per covered employee premiums in the micro-data sample to estimate the corresponding single coverage premiums.

The survey did not ask for premiums for family coverage directly. This was because AHIP member plans frequently had different premiums for families of different sizes or compositions. For example, some plans have separately determined premiums for an adult and one child, an adult and children, or two adults and children. Instead, family premiums were estimated based on the relationship between single and family coverage premiums for small firms (size 3 – 199) with all product types, as shown in Exhibit 1.13 of the 2005 Kaiser Family Foundation (KFF) employer health benefits survey. The KFF data on family premiums are for a family of four.

VII. ACKNOWLEDGEMENTS

This report provides a comprehensive, up-to-date overview of the characteristics of the small group health insurance market. On behalf of the health insurance plan community, AHIP would like to thank the member companies that provided the data for their extraordinary efforts.

The survey was designed and conducted by Hannah Yoo and Karen Heath of AHIP's Center for Policy and Research, and Tom Wildsmith, FSA, MAAA, of the Hay Group.

For further information, please contact Jeff Lemieux, Senior Vice President at AHIP's Center for Policy and Research, at 202.778.3200 or visit www.ahipresearch.org.

America's Health Insurance Plans

601 Pennsylvania Ave., NW
South Building
Suite Five Hundred
Washington, D.C. 20004

202.778.3200
www.ahip.org