AHIP
Center for Policy and Research

Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits

Study finds greater affordability and access, broader benefits, and better financial protections than is widely known.

August 2005

In the fall of 2004, America's Health Insurance Plans (AHIP) conducted a comprehensive survey of member companies doing business in the individual health insurance market. The study shows that individually purchased major medical insurance was more affordable and accessible than may be widely known, and offered a broad array of benefits. Most applications for coverage were approved with no restrictions, and the benefits commonly purchased by consumers provided substantial financial protection.

In some states with restrictions on premium variation and underwriting -- often known as "community-rated" states -- overall premiums were significantly higher.

The survey was divided into three components:
- premiums,
- underwriting, and
- benefits.

The survey of individual market premiums included just under 1.9 million policies, covering approximately 3.2 million individuals. The survey of underwriting and offer rates was based on over 925,000 individual applicants and a total of almost 1.1 million applications for coverage. The benefits survey included data on 500,000 single policies and 230,000 family policies. This represents the most extensive industry survey of individual coverage undertaken to date.[1]

Key findings:

- Nationwide, annual premiums averaged $2,268 for single coverage and $4,424 for a family plan in 2004. For single policies, annual premiums ranged from $1,170 for a person aged 18-24 to $4,185 for a person aged 60-64. For family policies, premiums ranged from $1,832 for policies covering only children under age 18 to $7,248 for families headed by a person aged 60-64.

[1] See also Thomas D. Musco, *Individual Medical Expense Insurance Affordable, Serves Young and Old*, Health Insurance Association of America, July 2002; Thomas D. Musco and Thomas F. Wildsmith, *Individual Health Insurance: Access and Affordability*, Health Insurance Association of America, October 2002; and Thomas F. Wildsmith, *Individual Health Insurance: Wide Choice of Benefits Available*, AAHP-HIAA, February 2004.

- Individual coverage is purchased by people of all ages. Forty-three percent of single policies were held by people between 25 and 44 years old; 25 percent were held by people aged 45-64; and 32 percent were held by people aged 24 and under. Likewise, 60 percent of family policies were purchased by families headed by a person aged 25-44; 33 percent were held by families headed by someone aged 45-64; and 8 percent were held by a family headed by an individual aged 24 or younger.

- Premiums varied by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences. Average annual premiums for single policies ranged from $1,885 in California to $6,048 in New Jersey; however, approximately 94 percent of the single policies surveyed were sold in states where the average premium was under $3,000. For family policies, average annual premiums ranged from $2,985 in New Mexico to $14,403 in New Jersey, but 98 percent of family policies in the survey were sold in states where the average premium was under $6,000.

- Approximately 88 percent of applicants were offered coverage. Offer rates varied from a high of 95 percent for applicants under age 18 to 70 percent for applicants aged 60-64. Seventy-seven percent of offers in the survey were at standard rates; 22 percent were at higher rates, and 1 percent included a coverage exception for a specified condition.

- Consumers in the individual market were offered a wide range of benefits, including mental health, prescription drug, and maternity benefits. Likewise, consumers chose from a diverse set of products, ranging from indemnity plans, to health savings accounts (HSAs), preferred provider organizations (PPOs), and health maintenance organizations (HMOs).

- One measure of the financial protection provided by an insurance policy is the limit placed on the consumer's annual out-of-pocket spending. Most consumers picked plans with annual out-of-pocket limits under $4,000.

- Another important measure of financial protection provided by a policy is the lifetime maximum benefit. All plans had lifetime maximum benefits of $1 million or more. Most consumers picked plans with lifetime maximums of more than $2 million, and the average was nearly $5 million.

- Cost containment and care management techniques were widely used. Virtually all plans (over 90 percent in each product category) covered case management services to help patients receive coordinated care. Almost 100 percent of the HMO/POS plans and over 80 percent of PPO plans covered disease management services.

Respondents to AHIP's survey were asked to include only major medical coverage that meets the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of guaranteed renewable and "creditable coverage." They were asked to report all such coverage marketed to individuals, whether as individual insurance policies or as certificates of coverage under an association group or other similar arrangement. 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 85 percent of the cost of single coverage, and 72 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, each consumer pays the entire cost, deciding whether the potential benefits justify 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, 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.

In a few states, age-based premiums and medical underwriting for new policies are not allowed. However, those states tend to have higher average premiums. 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.

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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 2004 Current Population Survey*, Issue Brief Number 276, Employee Benefit Research Institute, December 2004.

[3] Jon Gabel, Gary Claxton, et al., *Employer Health Benefits: 2004*, The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 2004, p. 72.

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

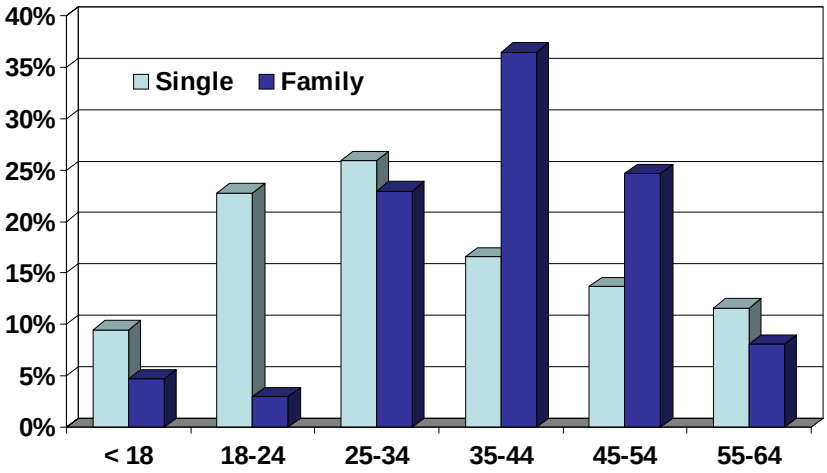
II. Premiums

AHIP members with individual major medical insurance plans in force as of June 30, 2004 were asked to submit annualized premium information, broken out by age and state. Data were collected on 1,875,261 policies, covering approximately 3.2 million individuals.[5]

Premiums by Age

Individual insurance was purchased by people in all age brackets. Forty-three percent of single policies were held by persons between 25 and 44 years old. Twenty-five percent were held by people aged 45-64; and 32 percent were held by people age 24 and under.

Figure 1. Individual Health Insurance: Distribution of Policyholders by Age



Source: America's Health Insurance Plans.

Of family policies, 60 percent were purchased by families headed by a person aged 25-44; 33 percent were held by families headed by someone aged 45-64; and 8 percent were held by a family headed by an individual age 24 or younger (see Figure 1).

In mid-2004, the average annual premium for single coverage was $2,268; and for family coverage the average premium was $4,424 for approximately three people (see Table 1 on page 5). For single policies, annual premiums ranged from $1,170 for a person aged 18-24 to $4,185 for a person aged 60-64. For family policies, annual premiums ranged from $1,832 for policies covering children under age 18 to $7,248 for families headed by a person aged 60-64.

Premiums by State

Premiums varied significantly by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences. In general, these factors affect premiums for single and family policies in similar ways.

[5] Based on survey responses indicating that family policies cover, on average, approximately three people.

Table 1
National Average Premiums by Age, 2004

	Single		Family		
	Policies in Survey	Average Annual Premium	Policies in Survey	Average Members per Family	Average Annual Premium
< 18	83,817	$1,183	20,576	2.16	$1,832
18-24	195,520	$1,170	10,468	2.26	$2,459
25-29	135,596	$1,345	29,559	2.62	$2,844
30-34	123,635	$1,608	65,588	3.02	$3,354
35-39	109,513	$1,826	97,252	3.34	$3,677
40-44	111,736	$2,262	122,599	3.39	$4,146
45-49	111,141	$2,638	119,371	3.22	$4,541
50-54	113,191	$3,173	89,295	2.81	$5,297
55-59	116,020	$3,775	60,108	2.35	$6,253
60-64	126,978	$4,185	33,298	2.12	$7,248
Total	1,227,147	$2,268	648,114	2.98	$4,424

Source: America's Health Insurance Plans.

Table 2 (on page 6) shows average premiums by state for single policies. Premiums for single policies ranged from $1,885 in California to $6,048 in New Jersey.

Table 3 (on page 7) shows premiums for family policies, which ranged from $2,985 in New Mexico to $14,403 in New Jersey. Carriers were instructed to assign each policy to the state on which its premium was based, rather than the state in which it was originally issued, and states with fewer than 500 policies were not reported separately.

In general, states with community rating and other rules restricting rate variation by age or health status had higher overall premiums. For example, New Jersey, which does not allow medical underwriting and uses a community rating rule, had premiums roughly 2 to 3 times higher than the national average for the individual market.

However, most policies reported in the survey were sold in states where average premiums were much closer to the national average. Approximately 94 percent of the single policies surveyed were sold in states where the average annual premium was under $3,000. Likewise, about 98 percent of family policies in the survey were in sold states where the average premium was under $6,000.

Table 2
Average Annual Premiums by State – Single Coverage, 2004

State	Policies in Survey	Average Annual Premium
New Jersey	29,198	$6,048
Massachusetts	14,104	$5,257
New York	5,932	$3,743
Arkansas	1,633	$3,435
South Carolina	6,156	$3,328
Maryland	1,285	$3,279
West Virginia	941	$3,141
New Hampshire	3,348	$3,134
South Dakota	1,944	$3,133
Oklahoma	3,748	$3,047
Connecticut	4,358	$2,963
Georgia	5,742	$2,910
Louisiana	2,541	$2,858
Tennessee	7,647	$2,851
Texas	27,132	$2,836
Wyoming	1,586	$2,734
Mississippi	3,100	$2,729
North Carolina	13,953	$2,623
Illinois	22,035	$2,591
Alabama	2,415	$2,548
Florida	162,992	$2,539
Arizona	9,529	$2,440
North Dakota	1,579	$2,420
Montana	4,077	$2,418
Wisconsin	11,876	$2,373
Nevada	10,239	$2,364
Virginia	50,952	$2,332
Indiana	15,402	$2,330
Ohio	20,043	$2,304
Missouri	9,031	$2,299
Nebraska	5,848	$2,295
National	**1,227,147**	**$2,268**
Kansas	3,835	$2,260
Idaho	1,247	$2,207
Colorado	16,482	$2,198
Oregon	6,706	$2,162
Minnesota	12,846	$2,121
Kentucky	13,066	$2,033
Pennsylvania	6,814	$1,989
New Mexico	4,812	$1,982
Iowa	6,915	$1,965
Michigan	12,051	$1,926
California	680,338	$1,885

Source: America's Health Insurance Plans.
Note: Results from states with fewer than 500 policies are included in the totals, but not reported separately.

Table 3
Average Annual Premiums by State – Family Coverage, 2004

State	Policies in Survey	Average Annual Premium	Average Members per Policy
New Jersey	4,861	$14,403	n/a
Massachusetts	5,762	$10,126	2.83
New York	1,347	$9,696	3.39
Maryland	845	$6,574	3.00
Arkansas	1,018	$5,821	2.82
Connecticut	2,675	$5,660	3.15
New Hampshire	2,446	$5,382	3.04
West Virginia	570	$5,338	2.91
South Carolina	4,123	$5,230	3.07
South Dakota	1,665	$5,228	3.22
Nevada	2,663	$5,096	3.04
Tennessee	5,131	$5,047	3.02
Illinois	14,320	$4,991	3.26
Georgia	4,008	$4,956	3.05
Texas	22,323	$4,940	3.15
Florida	85,445	$4,882	2.94
Louisiana	2,118	$4,874	3.14
Oklahoma	3,150	$4,813	3.02
Indiana	8,794	$4,803	3.08
Wyoming	1,621	$4,734	3.15
Mississippi	2,261	$4,721	3.11
Virginia	23,180	$4,631	1.74
Alabama	1,634	$4,545	2.84
Ohio	9,559	$4,541	3.14
Kansas	3,171	$4,510	3.18
North Carolina	8,293	$4,467	3.02
Wisconsin	8,641	$4,462	3.28
Kentucky	4,453	$4,442	3.03
National	**648,114**	**$4,424**	**2.98**
Montana	5,229	$4,350	3.17
Colorado	14,200	$4,216	3.18
Minnesota	10,826	$4,141	3.37
Nebraska	5,758	$4,119	3.37
North Dakota	1,893	$4,072	3.24
Missouri	6,601	$3,985	3.09
Arizona	7,346	$3,984	3.12
California	330,009	$3,972	3.00
Oregon	5,601	$3,971	3.06
Michigan	8,375	$3,968	3.21
Pennsylvania	4,868	$3,916	3.33
Idaho	2,114	$3,788	3.58
Iowa	5,943	$3,653	3.23
New Mexico	2,521	$2,985	2.99

Source: America's Health Insurance Plans.
Note: Results from states with fewer than 500 policies are included in the totals, but not reported separately.

III. Underwriting

This component of the survey was intended to provide detailed data on the medical underwriting process.[6] The questions were designed to measure offer rates by age, and to assess the types of coverage offered.

We requested underwriting information on applications for non-group major medical coverage received during the 12-month period ending on June 30, 2004 in states that permit medical underwriting. Respondents were asked to exclude applications from states which require guaranteed issue in the individual market, such as New York, New Jersey, Washington and Maine.[7]

AHIP members were asked to provide information on the number of applications for individual coverage received, those that were not processed or were denied for reasons unrelated to the health of the applicant, the number denied for medical reasons, and the number where coverage was offered. For those where coverage was offered, carriers were asked to specify the type of offer -- that is, whether a higher premium was required or a condition waiver was applied. We requested that carriers provide this information by five-year age bands based on the age of the primary applicant. Because an application for family coverage will include more than one person, carriers were also asked to provide the same information by individual applicant.

Data were collected on 1,074,646 total applications and 926,300 individual applicants. All of the participants reporting data by individual applicant were able to provide the data broken down by age.

Key Findings

A significant number of applications for individual health insurance never make it to the medical underwriting process. The reasons for this vary. For instance, the agent forwarding the application may not be registered with the insurer, the required premium payment may be missing, or the individual may obtain coverage elsewhere before the application is fully processed. Applicants may also be denied coverage for reasons having nothing to do with health status, such as living outside the health plan's service area. Overall, approximately 15 percent of total applications received were either not processed or denied for non-medical reasons; the remaining 85 percent went through the medical underwriting process and serve as the basis for the analysis of offer rates in the survey (see Table 4 on page 9).

In states where medical underwriting is allowed for new policies, the offer rate for individual applicants was approximately 88 percent (see Table 5 on page 9).

[6] 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 counteroffer with different benefits, a different premium, or both.

[7] Policies that were issued on a guaranteed basis to HIPAA-qualified individuals in states that do not have a general guaranteed-issue requirement were included. HIPAA is the Health Insurance Portability and Accountability Act of 1996, which 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, 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.

Table 4
Policies Underwritten, 2004
All Companies Reporting

	Received	Processing Not Completed	Non-Medical Denials	Policies Activated and Medically Underwritten
Individual Applicants	927,300	79,711	52,363	795,226
Total Applications	1,074,646	120,980	46,404	907,262
	As a Percentage of Applications Received			
Individual Applicants	100.0%	8.6%	5.6%	85.8%
Total Applications	100.0%	11.3%	4.3%	84.4%

Source: America's Health Insurance Plans.

Table 5
Analysis of Offer Rates, 2004
All Companies Reporting

	Medically Underwritten	Denials	Offers	Medically Underwritten	Denials	Offers
Individual Applicants	795,226	99,284	696,410	100.0%	12.5%	87.6%

Source: America's Health Insurance Plans.
Notes: The way in which applications and underwriting decisions are categorized and tracked varies among insurers. Reported totals will not match the sum of the subcategories. The difference does not exceed 0.1 percent of the total.

Offer rates varied by age, ranging from 95 percent for people under age 18 to 70 percent for people aged 60-64 (see Table 6 on page 10). As might be expected, the highest offer rates were for children. The offer rate was fairly stable at just under 90 percent from age 18 to age 39, then begins declining around age 45.

Importantly, even when the primary applicant was aged 60 to 64, most applications for individual coverage resulted in an offer of coverage (70 percent). Likewise, 75 percent of people aged 55 to 59 were offered coverage, and 80 percent of people between the ages of 50 and 54 were offered coverage.

Table 6
Analysis of Offer Rates, 2004
Companies Reporting Results by Age
Number of Individual Applicants

Age of Individual Applicant	Medically Underwritten	Denials	Offered	Denials	Offered
< 18	198,684	9,893	188,803	5.0%	95.0%
18 - 24	107,790	11,439	96,349	10.6%	89.4%
25 - 29	79,554	9,225	70,732	11.6%	88.9%
30 - 34	75,236	8,673	66,571	11.5%	88.5%
35 - 39	71,856	8,720	63,137	12.1%	87.9%
40 - 44	71,489	9,526	61,976	13.3%	86.7%
45 - 49	61,379	9,734	51,648	15.9%	84.1%
50 - 54	50,528	10,304	40,234	20.4%	79.6%
55 - 59	41,329	10,535	30,809	25.5%	74.5%
60 - 64	37,351	11,234	26,148	30.1%	70.0%
Average				12.5%	87.6%
Total	795,196	99,283	696,407		

Source: America's Health Insurance Plans.
Notes: The way in which applications and underwriting decisions are categorized and tracked varies among insurers. Reported totals will not match the sum of the subcategories for some age groups. The difference did not exceed 0.5 percent of the total for any age group.

The type of offer is also important.[8] Roughly three-quarters (77 percent) of individuals offered coverage were offered the coverage they requested at a standard premium rate (see Table 7 on page 11). Applicants who did not qualify for standard coverage were likely to be offered a higher initial premium (22 percent). A much smaller number of applicants were offered a condition waiver or exception from coverage (1 percent).

The type of offer made also varied by age. Children under age 18 were the most likely to be offered coverage at standard rates. Higher initial premiums were much more common than condition waivers. The number of applicants offered a higher premium was relatively stable for adults under age 35, then began to rise with age, with the largest increases occurring above age 45. Still, slightly more than half (56 percent) of the offers of coverage to adults age 60 to 64 were at standard rates.

[8] One company was unable to break down offers of coverage by type, and another company was able to provide detailed information on the type of offer, but was unable to report the number of applications received. Because of this, the number of offers shown in the tables analyzing offers by type differs slightly from those shown in the tables analyzing offer rates.

Table 7
Analysis of Offers by Type, 2004
Companies Reporting Results by Age
Individual Applicants

Type of Offer (Number of Policies)

Age of Individual Applicant	Number Offered	Standard Premium	Higher Premium	Condition Waiver	Higher Prem. & Condition Waiver	Other
< 18	197,273	171,029	24,712	260	52	1,383
18 - 24	102,853	81,580	20,644	781	153	280
25 - 29	73,618	56,588	16,587	789	153	0
30 - 34	68,663	52,422	15,605	975	247	4
35 - 39	64,836	47,823	16,157	1,247	316	0
40 - 44	63,575	45,712	16,786	1,425	398	38
45 - 49	52,895	36,772	14,933	1,277	512	70
50 - 54	41,158	27,185	12,797	1,098	570	108
55 - 59	31,655	19,227	11,340	910	598	101
60 - 64	27,164	15,329	11,038	778	508	23
Total	723,693	553,670	160,599	9,540	3,507	1,958

Type of Offer (Percent of Policies)

Age of Individual Applicant	Number Offered	Standard Premium	Higher Premium	Condition Waiver	Higher Prem. & Condition Waiver	Other
< 18	100.0%	86.7%	12.5%	0.1%	0.0%	0.7%
18 - 24	100.0%	79.3%	20.1%	0.8%	0.1%	0.3%
25 - 29	100.0%	76.9%	22.5%	1.1%	0.2%	0.0%
30 - 34	100.0%	76.3%	22.7%	1.4%	0.4%	0.0%
35 - 39	100.0%	73.8%	24.9%	1.9%	0.5%	0.0%
40 - 44	100.0%	71.9%	26.4%	2.2%	0.6%	0.1%
45 - 49	100.0%	69.5%	28.2%	2.4%	1.0%	0.1%
50 - 54	100.0%	66.1%	31.1%	2.7%	1.4%	0.3%
55 - 59	100.0%	60.7%	35.8%	2.9%	1.9%	0.3%
60 - 64	100.0%	56.4%	40.6%	2.9%	1.9%	0.1%
Average		76.5%	22.2%	1.3%	0.5%	0.3%

Source: America's Health Insurance Plans.

Notes: The way in which applications and underwriting decisions are categorized and tracked varies among insurers. In addition, more than one type of offer may be made on a single application. Reported totals will not match the sum of the subcategories. The difference increases with age, perhaps reflecting an increase in the number of alternative offers made as individuals age. The difference does not exceed 1.9 percent of the total for any age group.

IV. Benefits

This component of the survey was intended to provide detailed data on the benefits that are available to consumers in the individual health insurance market, and the benefits that those consumers are choosing to buy.

Participants were asked to include data on major medical policies or certificates sold during the 12-month period ending on June 30, 2004. Data were limited to guaranteed-renewable plans that meet the HIPAA definition of creditable coverage. Respondents were asked to provide separate responses for indemnity plans, PPO coverage, HMOs that may have point-of-service (POS) options, and HSA or Archer Medical Savings Account (MSA) plans.

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

This survey did not attempt to distinguish between separate or combined deductibles for in-network and out-of-network services. Deductibles were reported as if an enrollee used only in-network providers.

Twenty AHIP member companies responded to the survey on benefits, providing data on 499,850 single policies and 230,539 family policies sold to consumers. Assuming that family policies covered approximately three individuals, this represents well over a million covered lives. The most commonly purchased product among the survey responses was PPO coverage, which represented more than eight out of ten policies sold (see Table 8).

Table 8
Policies Sold During Study Period, 2004

	Number of Policies in Survey			
Product Type	Single		Family	
PPO	425,521	85.1%	183,741	79.7%
HSA/MSA	34,481	6.9%	36,090	15.7%
HMO/POS	30,120	6.0%	8,087	3.5%
Indemnity	9,728	1.9%	2,621	1.1%
Total	499,850	100.0%	230,539	100.0%

Source: America's Health Insurance Plans.

Key Findings

A wide variety of deductible levels were available, particularly for indemnity and PPO plans (see Table 9 below, and Table 10 on page 14). PPO products were available with first-dollar coverage, and indemnity plans were available with deductibles as low as $150 to $250.

The average deductible for single coverage was approximately $2,000 for all products other than HMO/POS plans. Deductibles for HMO/POS plans averaged roughly $500. However, almost all HMO/POS plans had either no deductible, or a deductible in the $1,500 to $1,999 range. The average deductible for consumers purchasing family coverage was comparable to the average for single coverage for all products other than HSA/MSA policies.

Table 9
Distribution of Policies by Deductible Level, 2004
Indemnity and HSA/MSA

Percent of Policies in Survey

	Indemnity		HSA/MSA	
Deductible	Single	Family	Single	Family
$0 (none)	0.0%	0.0%	0.0%	0.0%
$1 - $499	18.2%	17.3%	0.0%	0.0%
$500 - $999	8.3%	9.4%	0.0%	0.0%
$1,000 - $1,499	9.9%	13.7%	1.0%	0.0%
$1,500 - $1,999	9.0%	10.3%	36.4%	0.0%
$2,000 - $2,599	3.9%	3.0%	14.0%	0.5%
$2,500 - $2,999	29.5%	25.6%	44.6%	0.0%
$3,000 - $3,999	0.1%	0.4%	0.2%	37.4%
$4,000 - $4,999	0.2%	0%	3.8%	11.6%
$5,000 - $5,999	10.1%	12.2%	0.1%	48.6%
$6,000 +	10.7%	8.4%	0.0%	1.8%
Lowest Offered	$150	$250	$1,000	$1,000
Highest Offered	$10,000	$10,000	$5,000	$10,000
Average Purchased	$2,018	$2,219	$2,364	$4,653

Source: America's Health Insurance Plans.

Table 10
Distribution of Policies by Deductible Level, 2004
PPO and HMO/POS

	Percent of Policies in Survey			
	PPO		HMO/POS	
Deductible	Single	Family	Single	Family
$0 (none)	7.9%	5.9%	65.9%	66.5%
$1 - $499	9.6%	8.8%	0.4%	0.6%
$500 - $999	14.2%	15.7%	0.2%	0.3%
$1,000 - $1,499	21.2%	21.8%	0.2%	0.3%
$1,500 - $1,999	7.4%	7.2%	33.3%	32.3%
$2,000 - $2,599	3.1%	5.0%	0.0%	0.0%
$2,500 - $2,999	25.1%	23.0%	0.0%	0.0%
$3,000 - $3,999	0.9%	2.0%	0.0%	0.0%
$4,000 - $4,999	0.2%	0.1%	0.0%	0.0%
$5,000 - $5,999	10.3%	10.2%	0.0%	0.0%
$6,000 +	0.2%	0.3%	0.0%	0.0%
Lowest Offered	$0	$0	$0	$0
Highest Offered	$10,000	$10,000	$1,500	$1,500
Average Purchased	$1,942	$2,081	$503	$490

Source: America's Health Insurance Plans.

Cost containment and care management programs were common offerings among all insurance types. Carriers were asked which programs they cover with each product type, and the results were weighted by the number of policies (see Table 11 on page 15).

Virtually all plans covered case management programs to coordinate care for patients (93 percent or more). Retrospective utilization review was also common (56 percent or more); it was covered most often with indemnity and HSA/MSA plans, and was less commonly covered among PPO and HMO/POS plans. With network-based managed care programs, and HMOs in particular, separate utilization review programs may not be needed. Coverage of disease management services was common among all product types other than HSA/MSA plans.

Table 11
Cost Containment and Care Management Programs, 2004

	Percent of Policies in Survey					
	Indemnity	HSA/MSA	PPO		HMO/POS	
			Single	Family	Single	Family
Concurrent Review	100.0%	99.1%	66.0%	74.3%	58.9%	60.0%
Retrospective Review	92.5%	99.0%	64.0%	72.1%	56.6%	58.1%
Case Management	92.5%	99.9%	98.1%	97.8%	99.2%	98.8%
Disease Management	74.2%	4.2%	84.4%	78.7%	99.2%	98.8%

Source: America's Health Insurance Plans.

One measure of the financial protection provided by an insurance policy is the limit placed on the consumer's annual out-of-pocket spending. Health insurance policies include a variety of provisions, such as deductibles and co-payments, which share the cost of covered medical expenses between the insurance company and the consumer. Out-of-pocket limits set a maximum amount on how much consumers must pay in a calendar year as a result of these cost-sharing provisions. All of the indemnity, PPO and HSA/MSA policies reported in the survey included such a limit. Out-of-pocket limits were less common among HMO/POS plans, which are structured around relatively modest co-payments rather than deductibles and coinsurance. Even so, well over half of the HMO/POS plans in the survey included an annual limit on out-of-pocket costs.

As with deductibles, consumers could choose from a wide range of annual out-of-pocket limits -- with some as low as $250 in the case of PPO coverage. Average out-of-pocket limits ranged from approximately $2,500 to $4,800, depending on the product involved. The average for family HSA/MSA policies was $4,758. Behind these averages is a broad distribution of consumer choices, with a considerable number of consumers choosing limits of less than $1,500 or more than $5,000 (see Table 12 on page 16).

Table 12
Annual Out-of-Pocket Limits, 2004

	Percent of Policies in Survey			
	Indemnity		HSA/MSA	
	Single	Family	Single	Family
Percentage Without an Out-of-Pocket Limit	0.0%	0.0%	0.0%	0.0%
Distribution of Policies with a Limit				
< $1,000	4.5%	5.6%	0.1%	0.1%
$1,000 - $1,499	13.9%	20.8%	3.3%	0.0%
$1,500 - $1,999	9.5%	10.0%	35.4%	0.0%
$2,000 - $2,499	32.1%	18.6%	9.1%	0.1%
$2,500 - $2,999	15.5%	5.7%	36.5%	0.0%
$3,000 - $3,999	5.3%	4.0%	9.8%	38.0%
$4,000 - $4,999	2.0%	4.9%	3.4%	10.0%
$5,000 - $7,499	13.1%	16.2%	2.4%	49.3%
$7,500 - $9,999	1.5%	3.4%	0.0%	1.9%
$10,000 +	2.6%	10.8%	0.0%	0.6%
Lowest Offered	$900	$900	$1,000	$2,000
Highest Offered	$13,000	$13,000	$5,700	$10,000
Average Purchased	$2,780	$4,075	$2,483	$4,758

	Percent of Policies in Survey			
	PPO		HMO/POS	
	Single	Family	Single	Family
Percentage Without an Out-of-Pocket Limit	0.0%	0.0%	55.9%	57.9%
Distribution of Policies with a Limit				
< $1,000	2.6%	2.3%	0.0%	0.0%
$1,000 - $1,499	10.3%	10.3%	1.9%	2.8%
$1,500 - $1,999	4.7%	4.7%	1.6%	0.0%
$2,000 - $2,499	14.6%	17.5%	3.3%	1.8%
$2,500 - $2,999	8.7%	9.3%	0.0%	0.0%
$3,000 - $3,999	15.4%	15.9%	93.3%	95.0%
$4,000 - $4,999	9.7%	11.1%	0.0%	0.0%
$5,000 - $7,499	12.7%	12.2%	0.0%	0.0%
$7,500 - $9,999	21.1%	16.5%	0.0%	0.0%
$10,000 +	0.2%	0.3%	0.0%	0.0%
Lowest Offered	$250	$250	$500	$500
Highest Offered	$15,000	$20,000	$3,000	$3,000
Average Purchased	$3,873	$3,616	$2,906	$2,920

Source: America's Health Insurance Plans.

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

With indemnity plans, 20 to 29 percent coinsurance rates were most common (see Table 13). The average coinsurance percentage was significantly lower for both HSA/MSA and HMO/POS plans. For HMO/POS plans, this is likely due to a reliance on co-payments as an alternative form of cost sharing. For HSA/MSA plans, there was a relatively narrow corridor between the deductible levels and out-of-pocket limits. This means that if coinsurance is used with an HSA/MSA plan, it will apply to relatively few expenses before the annual out-of-pocket limit is reached and 100 percent coverage begins. This may limit the value of including a coinsurance provision -- for example, over 80 percent of the HSA/MSA plans surveyed did not use coinsurance.

Table 13
Coinsurance Levels, 2004

	Percent of Policies in Survey					
	Indemnity		HSA/MSA		HMO/POS	
Coinsurance Level	Single	Family	Single	Family	Single	Family
No Coinsurance	54.6%	47.3%	83.8%	87.7%	57.7%	58.8%
Less than 10%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10% - 19%	0.0%	0.0%	0.0%	0.0%	0.8%	1.2%
20% - 29%	38.4%	40.7%	5.7%	2.8%	41.4%	40.0%
30% - 39%	0.6%	0.5%	0.0%	0.0%	0.0%	0.0%
40% - 49%	0.0%	0.0%	0.4%	0.5%	0.0%	0.0%
50% or more	6.4%	11.4%	10.1%	9.0%	0.0%	0.0%
Lowest	0%	0%	0%	0%	0%	0%
Highest	50%	50%	50%	50%	20%	20%
Average	26.8%	24.6%	6.7%	5.7%	10.6%	12.9%

Source: America's Health Insurance Plans.

In general, PPO plans use the coinsurance level as a primary tool to encourage use of network providers. According to the survey, the average in-network coinsurance level for PPOs was roughly 20 percentage points lower than the out-of-network coinsurance level, for both single and family coverage (see Table 14 on page 18).

Table 14
Coinsurance Levels - PPO Plans, 2004

	Percent of Policies in Survey			
	Single		Family	
Coinsurance Level	In-Net	Out-of-Net	In-Net	Out-of-Net
No Coinsurance	8.6%	6.8%	9.4%	2.4%
Less than 10%	0.0%	0.0%	0.0%	0.0%
10% - 19%	1.4%	0.0%	1.5%	0.0%
20% - 29%	45.9%	0.0%	48.6%	0.0%
30% - 39%	27.2%	0.0%	25.6%	0.0%
40% - 49%	8.4%	93.2%	0.2%	97.6%
50% or more	8.6%	0.0%	14.8%	0.0%
Lowest	0%	0%	0%	0%
Highest	50%	60%	50%	60%
Average	23.6%	42.1%	23.6%	42.8%

Source: America's Health Insurance Plans.

Another important measure of the level of financial protection provided by a policy is the lifetime maximum benefit. Every carrier submitting data offered lifetime benefits of at least $1 million -- most offered coverage up to $5 million (see Table 15 on page 19). In the case of HMO plans, virtually all (99 percent) of the policies sold had unlimited maximum benefits -- as did roughly a third of the indemnity policies.

The majority of PPO and MSA/HSA policies purchased provided at least a $2 million dollar maximum benefit, and the average maximum benefit for these policies was roughly $5 million. Due to the very small number of HMO/POS policies sold with a lifetime maximum benefit, the data on the distribution of those policies by dollar amount of the limit was not calculated.

Table 15
Distribution of Policies by Lifetime Maximum Benefit, 2004

	Percent of Policies in Survey			
	Indemnity		HSA/MSA	
	Single	Family	Single	Family
Unlimited	38.2%	27.0%	0.0%	0.0%
Policies with Limit				
< $1,000,000	0.0%	0.0%	0.0%	0.0%
$1,000,000 - $1,999,999	14.3%	3.8%	1.9%	0.9%
$2,000,000 - $2,999,999	51.0%	57.0%	14.0%	11.7%
$3,000,000 - $3,999,999	10.3%	14.0%	36.9%	38.1%
$4,000,000 - $4,999,999	0.0%	0.0%	0.0%	0.0%
$5,000,000 - $7,499,999	24.4%	25.2%	26.9%	22.1%
$7,500,000+	0.0%	0.0%	20.2%	27.3%
Lowest Offered	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Highest Offered	$6,000,000	$6,000,000	$8,000,000	$8,000,000
Average Purchased	$1,924,397	$3,059,248	$5,162,260	$5,162,260

	Percent of Policies in Survey			
	PPO		HMO/POS	
	Single	Family	Single	Family
Unlimited	1.7%	1.9%	99.2%	98.8%
Policies with Limit				
< $1,000,000	0.0%	0.0%		
$1,000,000 - $1,999,999	0.5%	0.4%		
$2,000,000 - $2,999,999	6.4%	12.9%		
$3,000,000 - $3,999,999	3.2%	6.3%		
$4,000,000 - $4,999,999	0.0%	0.0%		
$5,000,000 - $7,499,999	88.6%	78.3%		
$7,500,000+	1.4%	2.0%		
Lowest Offered	$1,000,000	$1,000,000		
Highest Offered	$8,000,000	$8,000,000		
Average Purchased	$4,799,752	$4,626,453		

Source: America's Health Insurance Plans.

Co-payments are a common form of cost sharing among network-based managed care programs. Four out of ten PPO policies, and virtually all HMO/POS policies (99 percent), included a primary care office visit co-payment (see Table 16 on page 20). Low co-payments can be used to encourage use of primary care or in-network services, instead of more expensive or lower quality providers.

Consumers purchasing single coverage chose, on average, slightly higher co-payments than those purchasing family coverage. The distribution of co-payments was split for HMO/POS plans, with one large group of consumers choosing co-payments of $10 to $19.99, and another group choosing co-payments of $25 to $39.99.

None of the carriers participating in the study reported any indemnity or HSA/MSA policies that included a primary care co-payment. With the exception of certain preventive care services, HSAs and MSAs cannot provide coverage for services before the deductible is met.

Table 16
Primary Care Office Visit Co-payments, 2004

	Percent of Policies in Survey			
	PPO		HMO/POS	
	Single	Family	Single	Family
Policies with a Co-payment	45.5%	41.1%	99.2%	98.8%
Co-payment				
Less than $10	0.0%	0.0%	0.0%	0.0%
$10 - $14.99	3.8%	2.6%	43.2%	41.5%
$15 - $19.99	0.0%	0.0%	17.0%	24.1%
$20 - $24.99	21.7%	23.1%	0.0%	0.0%
$25 - $29.99	25.5%	34.4%	9.0%	15.7%
$30 - $39.99	16.6%	38.2%	30.8%	18.7%
$40 - $49.99	32.4%	1.6%	0.0%	0.0%
$50 or more	0.0%	0.0%	0.0%	0.0%
Lowest Offered	$10.00	$10.00	$10.00	$10.00
Highest Offered	$50.00	$50.00	$30.00	$30.00
Average Purchased	$29.12	$26.16	$19.09	$17.69

Source: America's Health Insurance Plans.

Almost all HMO/POS plans also used co-payments for specialist office visits. Among PPO plans, the use of specialist co-payments was less common than the use of primary care co-payments. The HMO/POS plans participating in the survey used the same co-payments for both primary care physicians and specialists (see Table 17 on page 21). For PPO plans, however, the average specialist co-payment is somewhat higher than the average primary care co-payment.

Table 17
Specialist Office Visit Co-payments, 2004

	Percent of Policies in Survey			
	PPO		HMO/POS	
	Single	Family	Single	Family
Policies with Co-payment	29.8%	25.2%	99.2%	98.8%
Co-payment				
Less than $10	0.0%	0.0%	0.0%	0.0%
$10 - $14.99	3.8%	2.7%	43.2%	41.5%
$15 - $19.99	0.0%	0.0%	17.0%	24.1%
$20 - $24.99	14.7%	15.3%	0.0%	0.0%
$25 - $29.99	14.2%	20.4%	9.0%	15.7%
$30 - $39.99	23.6%	46.4%	30.8%	18.7%
$40 - $49.99	43.7%	15.2%	0.0%	0.0%
$50 or more	0.0%	0.0%	0.0%	0.0%
Lowest Offered	$10.00	$10.00	$10.00	$10.00
Highest Offered	$40.00	$40.00	$30.00	$30.00
Average Purchased	$33.60	$29.95	$19.09	$17.69

Source: America's Health Insurance Plans.

Co-payments may also be used for inpatient hospital stays, as an alternative to deductibles and coinsurance. This approach is only common among HMO/POS plans. For plans using this approach, the average per diem co-payment was $290 (see Table 18).

Table 18
Hospital Per Diem Co-payments, 2004

	Indemnity		HSA/MSA		PPO		HMO/POS	
	Single	Family	Single	Family	Single	Family	Single	Family
Percent of Policies with Per Diem Co-payment	0.9%	0.9%	0.0%	0.0%	7.0%	5.7%	45.8%	34.5%
	Percent of Policies in Survey with a Co-payment							
Co-payment								
Less than $100	0.0%	0.0%			0.0%	0.0%	0.0%	0.0%
$100 - $149.99	0.0%	0.0%			0.0%	0.0%	5.0%	5.0%
$150 - $199.99	0.0%	0.0%			0.0%	0.0%	0.0%	0.0%
$200 or more	100 %	100%			100%	100%	95.0%	95.0%
Lowest Offered	$200	$200			$400	$400	$100	$100
Highest Offered	$200	$200			$400	$400	$300	$300
Average Purchased	$200	$200			$400	$400	$290	$290

Source: America's Health Insurance Plans.

There are two primary ways of providing coverage for prescription drugs: on an "integrated" basis, subject to the same deductible, coinsurance and other benefit provisions as any other medical expense, or through a separate "drug card" benefit subject to its own deductibles and co-payments. Every carrier participating in the survey reported offering drug coverage through one of these two methods.

To measure the availability and popularity of prescription drug coverage, we looked at the number of policies purchased from companies offering each type of coverage, and the number of policies purchased with the coverage.

Drug cards were a very popular feature for all products other than those marketed for use with an HSA or MSA plan. (With the exception of drugs prescribed in conjunction with certain preventive care services, prescription drug coverage provided by HSA or MSA plans must be subject to the plan's deductible, just like any other medical expense. Given that constraint, most HSA/MSA plans in the survey used "integrated" drug coverage rather than a separate drug card.) Virtually all PPO and HMO plans were purchased from carriers offering a drug card, and most consumers elected to buy the drug card benefit (see Table 19). A majority of indemnity policies were purchased from carriers offering a drug card, and over half of consumers purchasing an indemnity plan chose to buy the drug card.

Table 19
Type of Drug Coverage, 2004

Percent of Policies in Survey with Drug Coverage Type

	Indemnity		HSA/MSA		PPO		HMO/POS	
	Single	Family	Single	Family	Single	Family	Single	Family
"Integrated"								
Offered	49.3%	41.7%	100%	100%	24.6%	24.8%	0.0%	0.0%
Purchased	48.4%	39.8%	98.5%	98.1%	11.0%	11.2%	0.0%	0.0%
Separate Drug Card								
Offered	61.8%	73.0%	0.0%	0.0%	99.7%	99.7%	100%	100%
Purchased	51.6%	60.2%	0.0%	0.0%	81.0%	81.0%	100%	100%

Source: America's Health Insurance Plans.

When prescription drug coverage is provided as a separate 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, and non-preferred brand name drugs. These different levels of coverage are called "tiers" and are intended to encourage the use of more cost effective drugs. Most separate drug benefits provided more than one tier of coverage; none of the participating carriers reported using more than four tiers (see Table 20).

Table 20
Separate "Drug Card" Benefits
Tiers of Coverage, 2004

	Percent of Policies in Survey					
	Indemnity		PPO		HMO/POS	
	Single	Family	Single	Family	Single	Family
1 Tier	15.8%	7.8%	24.7%	18.4%	0.0%	0.0%
2 Tiers	55.0%	61.9%	19.4%	23.8%	36.2%	48.6%
3 Tiers	29.2%	30.3%	3.7%	3.7%	0.0%	0.0%
4 Tiers	0.0%	0.0%	52.2%	54.2%	63.8%	51.4%
5 or More Tiers	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: America's Health Insurance Plans.

Cost sharing provisions varied significantly by drug tier. Co-payments were ubiquitous for the first tier, and averaged $10 to $15 (see Table 21 on page 24). Roughly half of indemnity plans offering a separate prescription drug benefit used a deductible for the first tier of coverage. The use of deductibles for the first tier of coverage was much less common among PPO plans; none of the carriers reported using a deductible for the first tier of drug coverage sold in conjunction with a POS or HMO plan.

The average co-payment increased significantly for the second tier, averaging $25 to $28. The use of deductibles and coinsurance was also more common at the second tier than the first tier.

For those policies using a third or fourth drug tier, the use of co-payments was less common than in the lower tiers, and when co-payments were used, the average co-payment increased significantly at higher tiers (see Table 22 on page 25). Coinsurance was the most common form of cost-sharing for drug card coverage, and was typically set at 50 percent for tiers 3 and 4.

Table 21
Separate "Drug Card" Benefits, 2004
Cost-Sharing Tiers 1 and 2

Policies in Survey	Indemnity		PPO		HMO/POS	
	Single	Family	Single	Family	Single	Family
Tier 1						
Policies with a Co-payment	100.0%	100.0%	88.5%	88.7%	100.0%	100.0%
Lowest	$10	$10	$0	$0	$10	$10
Highest	$70	$70	$70	$70	$20	$20
Average	$10	$10	$10	$10	$13	$15
Policies with an Annual Deductible	47.1%	57.5%	15.6%	22.6%	0.0%	0.0%
Lowest	$0	$0	$0	$0		
Highest	$500	$500	$1,000	$1,000		
Average	$423	$457	$70	$71		
Policies with Coinsurance	15.8%	7.8%	14.3%	13.5%	0.0%	0.0%
Lowest	0.0%	0.0%	0.0%	0.0%		
Highest	20.0%	20.0%	50.0%	50.0%		
Average	4.5%	2.2%	4.8%	2.5%		
Tier 2						
Policies with a Co-payment	100.0%	100.0%	100.0%	100.0%	98.7%	98.5%
Lowest	$25	$25	$15	$15	$5	$5
Highest	$25	$25	$35	$35	$30	$30
Average	$25	$25	$28	$28	$28	$28
Policies with an Annual deductible	56.0%	62.4%	59.7%	57.8%	64.9%	51.6%
Lowest	$0	$0	$0	$0	$100	$250
Highest	$500	$500	$750	$750	$250	$300
Average	$423	$457	$343	$304	$248	$250
Policies with Coinsurance	65.3%	67.2%	12.6%	19.6%	0.0%	0.0%
Lowest	20.0%	20.0%	20.0%	20.0%		
Highest	20.0%	20.0%	20.0%	20.0%		
Average	20.0%	20.0%	20.0%	20.0%		

Source: America's Health Insurance Plans.

Table 22
Separate "Drug Card" Benefits, 2004
Cost-Sharing Tiers 3 and 4

Policies in Survey	Indemnity		PPO		HMO/POS	
	Single	Family	Single	Family	Single	Family
Tier 3						
Policies with a Co-payment	100.0%	100.0%	51.9%	60.3%	0.0%	0.0%
Lowest	$35	$35	$0	$0		
Highest	$35	$35	$50	$50		
Average	$35	$35	$42	$42		
Policies with an Annual Deductible	0.0%	0.0%	7.0%	8.8%	0.0%	0.0%
Lowest			$0	$0		
Highest			$500	$500		
Average			$246	$255		
Policies with Coinsurance	0.0%	0.0%	48.1%	39.7%	100.0%	100.0%
Lowest			50.0%	50.0%	50.0%	50.0%
Highest			50.0%	50.0%	50.0%	50.0%
Average			50.0%	50.0%	50.0%	50.0%
Tier 4						
Policies with a Co-payment			0.0%	0.0%	0.0%	0.0%
Lowest						
Highest						
Average						
Policies with an Annual Deductible			90.6%	86.1%	100.0%	100.0%
Lowest			$0	$0	$250	$250
Highest			$750	$750	$250	$250
Average			$425	$437	$250	$250
Policies with Coinsurance			100.0%	100.0%	100.0%	100.0%
Lowest			25.0%	25.0%	50.0%	50.0%
Highest			50.0%	50.0%	50.0%	50.0%
Average			45.1%	42.7%	50.0%	50.0%

Source: America's Health Insurance Plans.

Companies were asked whether they offered a variety of specific benefits with their individual market products (either as an integral part of the policy, or as a separate rider), and how many of their customers chose to purchase them. The results, shown in Table 23 (on page 26) and Table 24 (on page 27), are weighted by the number of policies sold during the study period. The values reported for PPO and HMO plans are based on the benefits provided in-network.

Table 23
Specific Benefits - Indemnity and HSA/MSA, 2004

	Percent of Policies in Survey			
	Indemnity		HSA/MSA	
	Single	Family	Single	Family
Coverage was Offered (including by rider)				
Inpatient Mental Health	92.5%	88.3%	99.9%	99.9%
Outpatient Mental Health	92.5%	88.3%	99.9%	99.9%
Annual Ob/Gyn Visit	95.9%	97.0%	100.0%	100.0%
Adult Physicals	100.0%	100.0%	99.1%	99.7%
Well-Baby Care	100.0%	100.0%	100.0%	100.0%
Inpatient Substance Abuse	88.4%	85.3%	99.9%	99.9%
Outpatient Substance Abuse	88.4%	85.3%	99.9%	99.9%
Pre-Natal Care	95.9%	97.0%	100.0%	100.0%
Normal Delivery	95.9%	97.0%	100.0%	100.0%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Oral Contraceptives	92.5%	88.3%	99.9%	99.9%
Coverage was Purchased				
Inpatient Mental Health	91.3%	87.0%	91.5%	90.5%
Outpatient Mental Health	91.3%	87.0%	89.8%	88.4%
Annual Ob/Gyn Visit	95.9%	97.0%	98.5%	98.1%
Adult Physicals	96.9%	97.7%	97.5%	97.7%
Well-Baby Care	96.9%	97.7%	98.5%	98.1%
Inpatient Substance Abuse	87.0%	83.7%	88.9%	87.5%
Outpatient Substance Abuse	87.0%	83.7%	88.9%	87.5%
Pre-Natal Care	55.2%	52.4%	98.4%	98.0%
Normal Delivery	44.5%	36.7%	5.3%	6.3%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Oral Contraceptives	76.6%	63.1%	18.0%	13.6%

Source: America's Health Insurance Plans.

Table 24
Specific Benefits - PPO and HMO/POS, 2004

	Percent of Policies in Survey			
	PPO		HMO/POS	
	Single	Family	Single	Family
Coverage was Offered (including by rider)				
Inpatient Mental Health	98.1%	97.8%	99.2%	98.8%
Outpatient Mental Health	98.1%	97.8%	99.2%	98.8%
Annual Ob/Gyn Visit	97.4%	98.0%	100.0%	100.0%
Adult Physicals	74.3%	74.1%	100.0%	100.0%
Well-Baby Care	100.0%	100.0%	100.0%	100.0%
Inpatient Substance Abuse	94.9%	95.6%	99.2%	98.8%
Outpatient Substance Abuse	95.5%	95.8%	99.2%	98.8%
Pre-Natal Care	97.4%	98.0%	100.0%	100.0%
Normal Delivery	97.4%	98.0%	100.0%	100.0%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Oral Contraceptives	74.3%	74.1%	99.2%	98.8%
Coverage was Purchased				
Inpatient Mental Health	93.3%	91.8%	99.2%	98.8%
Outpatient Mental Health	93.2%	91.7%	99.2%	98.8%
Annual Ob/Gyn Visit	75.9%	86.2%	100.0%	100.0%
Adult Physicals	46.2%	58.0%	100.0%	100.0%
Well-Baby Care	77.9%	87.3%	100.0%	100.0%
Inpatient Substance Abuse	91.3%	91.3%	99.2%	98.8%
Outpatient Substance Abuse	92.2%	91.7%	99.2%	98.8%
Pre-Natal Care	56.4%	62.2%	99.2%	98.8%
Normal Delivery	33.9%	32.2%	99.2%	98.8%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Oral Contraceptives	73.0%	64.2%	90.3%	83.3%

Source: America's Health Insurance Plans.

All of the specific benefits studied were widely available in the market. The results suggest that the typical HMO benefit package automatically includes most of the optional benefits common in this market.

Some level of mental health coverage is included in nine out of ten policies purchased. Substance abuse coverage is only slightly less common. HSA/MSA products generally include preventive care, though most routine expenses are likely funded through the savings account. It appears that maternity-related benefits are among those that consumers are most likely to consider optional.

V. Acknowledgments

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This report was written by Thomas F. Wildsmith, FSA, MAAA, of the Hay Group. Teresa Chovan, Director of Research, and Hannah Yoo, Policy Analyst, of AHIP's Center for Policy and Research helped compile the data. Kaylene Lewek helped prepare the tables for publication.

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