AHIP
Center for Policy and Research

Small Group Health Insurance in 2008

March 2009

A Comprehensive Survey of Premiums, Product Choices, and Benefits

CONTENTS

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SUMMARY

In July 2008, 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 761,000 small groups (those with 50 or fewer employees), reflecting approximately 5 million workers and 3.9 million dependents with coverage as of January 2008. Over 80 percent of the small groups represented had 10 or fewer employees. In total, 23 AHIP member companies provided data for the survey, including large national and regional carriers, as well as single-state and local plans. This survey is an update to AHIP's 2006 survey of the small group market.[1]

Key survey results:

- In 2008, the average premium for small group health insurance was $346 per month ($4,155 per year) for single coverage and $913 per month ($10,956 annually) for family coverage.
- Within the small group market, premiums fell as firm size increased. Firms with between 26 and 50 employees paid an average of $311 per month for single coverage, while firms with between 11 and 25 employees paid an average of $332 per month, and firms with 10 or fewer employees had average single premiums of $378 per month.
- Small group premiums in 2008 were slightly lower than those reported in the 2008 Kaiser Family Foundation (KFF) survey that mostly represents larger employers. Premiums in the KFF survey for all firms with three or more employees averaged $392 per month ($4,704 annually) for single coverage, and $1,057 per month ($12,684 per year) for family coverage in 2008.[2]
- Employee cost-sharing tends to be somewhat higher among small group plans than in larger group plans. For example, the average annual deductible for preferred provider organization (PPO) plans reported by the KFF survey of mostly medium-size employers (3-199 employees) in 2008 was $917, while the average deductible for single coverage in the small group market (50 or fewer employees) in AHIP's 2008 survey was $1,059.
- Among states, average premiums ranged from a high of $504 per month for single coverage ($1,329 for family coverage) in Alaska to a low of $198 per month for single coverage ($521 for family coverage) in Washington.
- Among employees with small group coverage, 50 percent had a PPO plan in 2008, with both in-network and out-of-network benefits. Forty-one (41) percent had health maintenance organization (HMO) coverage,

[1] *Small Group Health Insurance in 2006: A Comprehensive Survey of Premiums, Consumer Choices, and Benefits*, AHIP Center for Policy and Research (September 2006).
[2] *Employer Health Benefits: 2008*, The Kaiser Family Foundation and Health Research and Educational Trust (September 2008). 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).

often with a point-of-service (POS) option. Seven (7) percent of enrollees had a health savings account (HSA) benefit, with a qualifying high-deductible health plan (HDHP).

- Nine (9) 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 an alternative plan, usually a PPO or HMO/POS plan. Forty-two (42) percent of enrollees in small groups chose HSA/HDHP plans when offered a choice among HSA plans and other types of health plans.

- PPO plans purchased by small employers had an average individual deductible of $1,059, an average coinsurance rate of 21 percent, average copayments of $23 for primary care physician visits (in-network), and an average annual out-of-pocket limit of $2,636. An average HSA plan had an individual deductible of almost $2,180 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 $2,850. An average HMO/POS plan in the small group market had copayments of about $20 for primary care office visits and about $35 for specialist visits.

In general, the calculations of averages and distributions were weighted by the number of covered workers. Respondents were asked to include data on policies or certificates in-force as of January 2008, and to provide data only for major medical plans that meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of creditable coverage.

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 and claims experience. 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 "guarantee-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, health status 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 and 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 regulations. 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 mostly regulated by the states, which set rules for benefits and premium rating.[3] 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, 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.[4] 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.[5] Therefore, individual self-selection is less common. However, firms with relatively few employees may be more likely to base their decisions to offer coverage 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.

[3] Some federal laws affect the individual market. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires guarantee issue of individual coverage for certain people with prior continuous coverage in the group market.
[4] See America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* (December 2007).
[5] 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 guarantee-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,” often plus or minus 25 percent from the standard rate based on health status or claims experience of the group. 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.

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 2008 survey was $346 per month for single coverage and $913 per month for family coverage (see Table 1). On an annual basis, this equates to $4,155 per year for single coverage and $10,956 for family coverage.[6]

TABLE 1. SMALL GROUP PREMIUMS, 2008

	Annual Premium		Monthly Premium	
	Single	Family	Single	Family
Firms with 50 or Fewer Employees	$4,155	$10,956	$346	$913

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

Premiums from more than 761,000 small groups are represented in the survey. Over 625,000 groups had 10 or fewer employees, with almost 2.2 million covered workers. There were over 97,000 groups in the survey with between 11 and 25 employees; these firms had almost 1.5 million covered workers. Small groups with between 26 and 50 employees were represented by over 38,000 firms in the survey, covering more than 1.3 million 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 lower premiums than those with fewer employees. For example, firms with between 26 and 50 employees paid an average of $311 per month for single coverage and $819 a month for family coverage. Firms with between 11 and 25 employees paid an average of $332 a month for single coverage and $876 for family coverage. Firms with 10 or fewer employees had average premiums of $378 a month for single coverage and $996 per month for family coverage.

In general, states require health insurers to pool claim experience for all small groups for purposes of establishing rates. Typically, all small group rates begin with an "index rate" that is computed from a carrier's claims experience for the 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 in the decisions of firms to offer coverage.

TABLE 2. PREMIUMS BY NUMBER OF COVERED EMPLOYEES IN SMALL GROUP PLANS, 2008

	Number of Groups in Survey	Total Covered Employees	Total Covered Lives	Average Monthly Premium - Single	Average Monthly Premium - Family
10 or Fewer Employees	625,508	2,162,455	3,863,192	$378	$996
11 - 25 Employees	97,279	1,464,485	2,611,083	$332	$876
26 - 50 Employees	38,464	1,335,421	2,393,257	$311	$819
All Small Groups	761,251	4,962,361	8,867,532	$346	$913

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

[6] 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 2008 survey to create estimates for a family of four.

TABLE 3. SMALL GROUP PREMIUMS VS. PREMIUMS FOR LARGER GROUPS, 2008		
	Monthly Premium	
	Single	Family
AHIP (Firms with 50 or Fewer Employees)	$346	$913
KFF (Firms with 3 or More Employees)	$392	$1,057
KFF (Firms with 3-199 Employees)	$382	$1,008
Sources: America's Health Insurance Plans, Kaiser Family Foundation/HRET Employer Health Benefits, 2008 Annual Survey. Note: Family premiums estimated for a family of four.		

Comparison with Premiums for Larger Groups

On average, large groups (those with more than 50 employees) appear to have higher premiums than small groups. However, this does not necessarily imply that small group coverage is less costly, because, to help keep premiums affordable, small firms tend to offer coverage with higher deductibles and copayments than large firms.

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 2008 than AHIP's survey of small group plans in 2008. KFF reported average premiums of $392 per month for single coverage, and $1,057 per month for family coverage in 2008. KFF reported that premiums for the smallest size-of-firm category in their survey -- those with 3 to 199 employees -- averaged $382 per month for single coverage, and $1,008 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 $917, while the average individual deductible for small groups in AHIP's survey was $1,059 (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, 2008		
	AHIP (Firms Size 50 or Fewer)	KFF (Firm Size 3-199)
Average Deductible	$1,059	$917
Sources: America's Health Insurance Plans, Kaiser Family Foundation/HRET Employer Health Benefits, 2008 Annual Survey.		

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, Ohio, Pennsylvania, Arizona, Missouri, Virginia, and Washington had lower-than-average premium rates. New York, Massachusetts, Illinois, Florida, New Jersey, and Maryland 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 guarantee-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 average premium rates by state for firms with between 26 and 50 employees; Table 7 (on page 11) shows average premiums by state for firms with 11-25 employees, and Table 8 (on page 12) shows average premiums for firms with 10 or fewer employees.

TABLE 5. PREMIUMS BY STATE, ALL SMALL GROUPS, 2008		
States	Average Monthly Premium Single	Average Monthly Premium Family
Alaska	$504	$1,329
Massachusetts	$458	$1,208
Rhode Island	$432	$1,139
New Hampshire	$420	$1,107
Maryland	$414	$1,091
Wyoming	$412	$1,087
West Virginia	$412	$1,085
New York	$407	$1,072
New Jersey	$401	$1,057
Utah	$397	$1,046
Illinois	$393	$1,035
Wisconsin	$388	$1,024
Connecticut	$388	$1,023
Florida	$383	$1,009
New Mexico	$380	$1,001
Texas	$369	$972
Colorado	$368	$969
District of Columbia	$366	$966
Nebraska	$365	$963
Oklahoma	$364	$960
Maine	$360	$948
North Carolina	$355	$936
Minnesota	$353	$932
California	$349	$920
Louisiana	$349	$919
United States	**$346**	**$913**
Montana	$340	$896
Nevada	$339	$893
Pennsylvania	$337	$889
Indiana	$333	$878
Georgia	$330	$870
Mississippi	$324	$854
Ohio	$320	$845
South Carolina	$319	$841
Kansas	$318	$839
Iowa	$317	$835
Missouri	$313	$826
Virginia	$313	$825
Arizona	$305	$803
Kentucky	$301	$793
South Dakota	$298	$787
Alabama	$296	$781
Arkansas	$283	$747
Michigan	$280	$738
Oregon	$275	$726
Tennessee	$274	$724
North Dakota	$250	$660
Washington	$198	$521

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, 2008		
States	Average Monthly Premium Single	Average Monthly Premium Family
Rhode Island	$423	$1,116
New Hampshire	$406	$1,071
New Jersey	$391	$1,031
Connecticut	$389	$1,026
New York	$379	$1,000
Wisconsin	$372	$980
Utah	$370	$975
Illinois	$362	$954
Florida	$361	$952
Minnesota	$351	$925
Oklahoma	$349	$921
Louisiana	$344	$906
Colorado	$343	$904
Texas	$343	$903
Pennsylvania	$337	$889
Maine	$330	$870
California	$328	$865
Nebraska	$328	$864
United States	**$311**	**$819**
Indiana	$310	$818
Mississippi	$307	$810
Georgia	$305	$804
Nevada	$301	$794
Ohio	$296	$782
North Carolina	$295	$777
Virginia	$294	$776
Kansas	$286	$753
Iowa	$286	$753
Kentucky	$284	$749
Michigan	$281	$741
Missouri	$279	$734
South Carolina	$272	$717
Arizona	$266	$700
Arkansas	$257	$678
Tennessee	$256	$675
Oregon	$252	$666
Washington	$183	$483

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, 2008		
States	Average Monthly Premium Single	Average Monthly Premium Family
Massachusetts	$451	$1,188
Rhode Island	$435	$1,146
Maryland	$408	$1,075
New Hampshire	$398	$1,049
Utah	$390	$1,029
New Jersey	$387	$1,019
Wyoming	$385	$1,016
West Virginia	$381	$1,005
New York	$376	$992
Wisconsin	$374	$985
Illinois	$373	$983
Connecticut	$364	$960
Florida	$360	$950
Minnesota	$345	$910
Colorado	$345	$910
New Mexico	$341	$898
Texas	$340	$897
Pennsylvania	$334	$881
Nebraska	$334	$880
Oklahoma	$333	$879
United States	**$332**	**$876**
Maine	$332	$875
California	$332	$874
Virginia	$327	$863
North Carolina	$316	$834
Nevada	$315	$831
Louisiana	$315	$831
Georgia	$315	$829
Indiana	$311	$820
Montana	$310	$816
Kansas	$302	$797
Mississippi	$299	$788
Iowa	$299	$788
Ohio	$299	$787
Missouri	$298	$786
South Carolina	$292	$770
Kentucky	$288	$759
Arizona	$287	$757
Tennessee	$280	$738
Michigan	$276	$728
Oregon	$272	$717
Alabama	$269	$710
Arkansas	$266	$702
Washington	$188	$497

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, 2008		
States	Average Monthly Premium Single	Average Monthly Premium Family
Massachusetts	$462	$1,219
New Hampshire	$437	$1,152
West Virginia	$437	$1,152
Wyoming	$434	$1,146
Rhode Island	$432	$1,140
Utah	$427	$1,125
New York	$424	$1,117
Illinois	$424	$1,117
Maryland	$419	$1,105
North Carolina	$410	$1,080
Wisconsin	$408	$1,075
New Jersey	$407	$1,074
Nebraska	$405	$1,068
New Mexico	$405	$1,067
Connecticut	$404	$1,064
Texas	$401	$1,058
Florida	$401	$1,057
Oklahoma	$391	$1,030
Louisiana	$388	$1,024
Maine	$387	$1,021
Colorado	$386	$1,017
United States	**$378**	**$996**
Nevada	$372	$980
Virginia	$367	$969
Indiana	$366	$966
California	$365	$963
Minnesota	$361	$952
South Carolina	$359	$948
Georgia	$357	$942
Montana	$355	$936
Mississippi	$351	$926
Arizona	$350	$922
Ohio	$347	$914
Kansas	$342	$903
Missouri	$341	$900
Iowa	$341	$899
Pennsylvania	$339	$894
Arkansas	$320	$843
Kentucky	$317	$837
Alabama	$312	$823
Tennessee	$311	$819
Oregon	$303	$799
Michigan	$282	$745
Washington	$265	$698
North Dakota	$256	$674

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

Premium Variation Among Small Firms

A subset of firms in the AHIP survey reported premiums in a format that allows distributional tabulations on premium variation. Thirteen AHIP member firms responded in this format, representing 2 million covered workers, or about forty (40) percent 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 50 states and the District of Columbia. The distributions described below are controlled to aggregated totals from the entire survey universe of 23 AHIP member companies.

Most states allow small group premiums to vary for the ages of the group of enrollees, geographic location, industry, and other demographic factors. Most states also allow rates to vary by health status or claims experience, typically within a band of plus or minus 25 percent around an index rate charged by an insurer to small groups in a state. Other factors affecting premium rates include the choice of products or benefit packages made by small employers or their employees.

Within the small group market, smaller firms have a somewhat higher degree of rate variation than larger firms. This difference is understandable, because average employee age typically varies more widely among very small firms. Because they have fewer workers, there is greater statistical fluctuation in the averages between groups. For example, premiums in the 90th percentile nationwide for groups with 10 or fewer employees (including all types of products and benefits) are over three times the premiums of the smallest groups in the 10th percentile of premiums (see Table 9). However, the rate variation nationwide is closer to a 2.5-1 ratio for firms with 10-50 employees.

TABLE 9. PREMIUM VARIATION BY SMALL GROUP SIZE, SINGLE MONTHLY PREMIUMS, 2008

	10th Percentile	Mean	90th Percentile	Ratio of 90th Percentile to 10th Percentile
10 or Fewer Employees	$173	$378	$638	3.7-1
11 - 25 Employees	$192	$332	$505	2.6-1
26 - 50 Employees	$189	$311	$459	2.4-1
All Small Groups	$166	$346	$576	3.5-1

Source: America's Health Insurance Plans

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. 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 more than 5.2 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.

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 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 PPOs 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 50 percent of the policies in-force, or more than 2.6 million employees (see Table 10). Forty-one percent of workers (nearly 2.2 million) had HMO/POS coverage; 7 percent of employees (389,000) had HSA/HDHP coverage.

Roughly 55,000 employees had HRA coverage and 14,600 employees had indemnity coverage.

TABLE 10. PRODUCT TYPE BY NUMBER OF COVERED EMPLOYEES, SMALL GROUP MARKET, 2008

	Number of Covered Employees in Survey	Distribution of Covered Employees
PPO	2,604,242	50%
HMO/POS	2,166,981	41%
HSA/HDHP	388,577	7%
HRA	55,494	1%
Indemnity	14,640	*
Total	5,229,934	100%

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

According to data from the subset of respondents who returned data in a format that allows distributional and firm-by-firm tabulations, the proportion of small firms offering a choice among products or benefit packages is relatively low (see Table 11). Based on this data, 91 percent of employees in firms with fewer than 50 workers were offered one plan; 9 percent were offered two plans; and only a very small fraction were offered three or more benefit plans.

TABLE 11. PROBABILITY OF A CHOICE OF PLANS OR BENEFIT PACKAGES, SMALL GROUP MARKET, 2008

	Small Groups (50 or fewer workers)
One Plan	91%
Two Plans	9%
Three or More Plans	1%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100% due to rounding.

However, among small groups offering HSA/HDHP coverage, approximately one-third offered employees additional coverage options (see Table 12). Among firms with 10 or fewer workers, 12 percent of workers offered an HSA/HDHP plan were also offered different health plans. By contrast, among firms with between 11 and 25 employees, 41 percent of employees offered HSA/HDHP coverage had alternative coverage options, and among groups with between 26 and 50 workers, nearly 50 percent of workers offered HSA/HDHP coverage had a choice of plan.

TABLE 12. CHOICES AVAILABLE TO EMPLOYEES WITH HSA/HDHP PLANS SMALL GROUP MARKET, 2008

	HSA/HDHP only option	HSA/HDHP with other options
1-10 Employees	88%	12%
11-25 Employees	59%	41%
26-50 Employees	52%	48%
All Small Groups	69%	31%

Source: America's Health Insurance Plans.

TABLE 13. OTHER PLANS AVAILABLE TO HSA/HDHP ENROLLEES WITH A CHOICE OF PLANS, SMALL GROUP MARKET, 2008

HMO & POS	77%
PPO	17%
HRA	4%
More than one	1%
Total	100%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100% due to rounding.

Among small groups offering HSA/HDHP coverage as an option, a HMO/POS plan was also available nearly 80 percent of the time, and a PPO plan was available about one-fifth of the time (see Table 13).

A relatively high percentage of people offered HSA/HDHP coverage chose it. Table 14 shows that roughly 40 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 (43 percent), 11-25 workers (42 percent), and 26-50 workers (41 percent).

TABLE 14. PERCENTAGE OF SMALL GROUP EMPLOYEES WITH A CHOICE OF HSA/HDHP PLAN OR OTHER PLANS THAT CHOOSE HSA/HDHP COVERAGE, 2008

1-10 Employees	43%
11-25 Employees	42%
26-50 Employees	41%
Average	42%

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 15 (on page 16) compares the out-of-pocket limits for HSA/HDHP plans and PPO plans with varying deductibles.

TABLE 15. COMPARISON OF AVERAGE ANNUAL OUT-OF-POCKET LIMITS (HSA PLANS VS. PPO PLANS), SMALL GROUP MARKET, 2008		
Annual Deductible	HSA/HDHP	PPO
$0 (no deductible)	-	$1,559
$1 - $249	-	$812
$250 - $499	-	$1,192
$500 - $749	-	$2,074
$750 - $999	-	$2,246
$1,000 - $1,499	$1,506	$2,265
$1,500 - $1,999	$2,223	$2,893
$2,000+	$3,321	$4,070
Overall	$2,866	$2,636
Source: America's Health Insurance Plans.		

IV. DETAILED BENEFIT INFORMATION

Benefits purchased by small groups are summarized in Table 16 and are explored in more detail in the tables that follow.

The average deductible for single coverage was approximately $1,059 for PPO plans, $2,200 for HSA/HDHP plans, and $1,020 for HMO/POS plans (see Table 17 on page 18). For HMO/POS and PPO plans, these averages reflect only those plans that have deductibles. All HSA/HDHP plans and 88 percent of PPO plans in the survey had deductibles. However, 66 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 21 percent (see Table 18 on page 18). By contrast, 71 percent of HSA/HDHP plans and almost half of HMO/POS plans did not include coinsurance. For HMOs, this is because copayments (often $25 or $35 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. Nearly all HMO/POS plans and 94 percent of PPO plans in the small group market charged copayments for primary care office visits (see Table 19 on page 19). Copayments averaged approximately $24 per visit in 2008.

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 $33 for HMO/POS coverage, while copayments for primary care averaged $22 (see Table 20 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 16. BENEFIT CHARACTERISTICS BY PRODUCT, SMALL GROUP MARKET, 2008

	HSA/HDHP	PPO	HMO/POS
Average Deductible (Single)	$2,179	$1,059	$1,020
Percent with a Deductible	100%	88%	66%
Average Annual Out-of-Pocket Maximum	$2,866	$2,636	$2,284
Percent with an Out-of-Pocket Maximum	100%	94%	92%
Average Coinsurance Level	22%	21%	23%
Percent with Coinsurance	29%	83%	54%
Average Lifetime Maximum Benefit	$4,875,045	$4,793,935	$4,517,261
Percent with a Lifetime Maximum	86%	84%	67%
Average Primary Care Office Visit Copayment	$28	$23	$22
Percent with Primary Care Copayment	22%	94%	99%
Average Specialist Visit Copayment	$34	$30	$33
Percent with Specialist Copayment	7%	93%	98%

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

TABLE 17. DISTRIBUTION OF POLICIES BY DEDUCTIBLE LEVEL, SMALL GROUP MARKET, 2008				
	Percent of Employees in Survey			
Deductibles (single)	HSA/HDHP	HRA	PPO	HMO/POS
$0 (no deductible)	0%	0%	12%	34%
$1 - $249	0%	0%	1%	0%
$250 - $499	0%	0%	17%	5%
$500 - $749	0%	1%	22%	15%
$750 - $999	0%	0%	2%	1%
$1,000 - $1,499	14%	10%	23%	20%
$1,500 - $1,999	17%	11%	8%	8%
$2,000 +	69%	78%	15%	17%
Lowest Offered	$1,100	$250	$200	$250
Highest Offered	$10,000	$10,000	$10,000	$7,000
Average Purchased	$2,179	$2,001	$1,059	$1,020

Source: America's Health Insurance Plans.

TABLE 18. COINSURANCE LEVELS, SMALL GROUP MARKET, 2008				
	Percent of Employees in Survey			
Coinsurance Level	HSA/HDHP	HRA	PPO	HMO/POS
No Coinsurance	71%	79%	17%	46%
Less than 10%	0%	0%	0%	0%
10% - 19%	2%	3%	15%	7%
20% - 29%	12%	15%	50%	26%
30% - 39%	15%	2%	2%	12%
40% - 49%	0%	*	16%	*
50%	0%	0%	*	9%
Lowest Offered	10%	10%	10%	10%
Highest Offered	40%	50%	50%	50%
Average Purchased	22%	20%	21%	23%

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

TABLE 19. PRIMARY CARE OFFICE VISIT COPAYMENTS, SMALL GROUP MARKET, 2008				
	HSA/HDHP	HRA	PPO	HMO/POS
Percentage of Policies With Primary Care Copay	22%	88%	94%	99%
Copayment Level	Percent of Employees in Survey			
Less than $10	*	*	*	*
$10 - $14.99	0%	0%	6%	8%
$15 - $19.99	18%	1%	15%	11%
$20 - $24.99	16%	20%	31%	35%
$25 - $29.99	0%	64%	18%	27%
$30 or more	65%	15%	30%	18%
Lowest Offered	$15	$10	$5	$5
Highest Offered	$50	$50	$50	$50
Average Purchased	$28	$25	$23	$22

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

TABLE 20. SPECIALIST OFFICE VISIT COPAYMENTS, SMALL GROUP MARKET, 2008				
	HSA/HDHP	HRA	PPO	HMO/POS
Percentage of Policies With Specialist Copay	7%	88%	93%	98%
Copayment Level	Percent of Employees in Survey			
Less than $10	*	*	*	*
$10 - $14.99	0%	0%	3%	4%
$15 - $19.99	5%	0%	9%	4%
$20 - $24.99	0%	14%	17%	21%
$25 - $29.99	13%	16%	17%	13%
$30 or more	82%	70%	54%	58%
Lowest Offered	$15	$20	$5	$5
Highest Offered	$60	$80	$80	$80
Average Purchased	$34	$36	$30	$33

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

In 2008, 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 92 percent of HMO/POS plans in the small group market have limits (see Table 21). Average out-of-pocket limits ranged from approximately $2,600 to $2,900 for HSA/HDHP and PPO plans. Among the HMO/POS plans with limits on annual out-of-pocket costs, the average limit was approximately $2,300. 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 lifetime limits on benefits. For example, 67 percent of HMO/POS plans in the survey had lifetime limits; 84 percent of PPO plans and 86 percent of HSA/HDHP plans also have a lifetime maximum (see Table 22 on page 21). Among small group plans with lifetime limits on benefits, the average limit ranged from $4.5 million for HMO/POS plans to $5 million for HRA/HDHP 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 $11 to $13; average copayments for preferred brand-name drugs ranged from $17 to $31; and copayments for non-preferred brand-name drugs averaged $32 to $50 (see Table 23 on page 21).

TABLE 21. ANNUAL OUT-OF-POCKET LIMITS, SMALL GROUP MARKET, 2008

	HSA/HDHP	HRA	PPO	HMO/POS
Percentage With an Out-of-Pocket Limit	100%	93%	94%	92%
Distribution of Policies With a Limit	Percent of Employees in Survey			
< $500	0%	0%	1%	15%
$500 - $999	0%	0%	2%	1%
$1,000 - $1,499	7%	6%	12%	7%
$1,500 - $1,999	13%	3%	10%	13%
$2,000 - $2,999	44%	65%	24%	29%
$3,000 +	36%	26%	51%	36%
Lowest Offered	$1,100	$1,000	$250	$250
Highest Offered	$10,200	$25,000	$25,000	$30,000
Average Purchased	$2,866	$2,341	$2,636	$2,284

Source: America's Health Insurance Plans.

TABLE 22. LIFETIME MAXIMUM BENEFITS, SMALL GROUP MARKET, 2008				
	HSA/HDHP	HRA	PPO	HMO/POS
Percentage With Lifetime Limits	86%	99%	84%	67%
Distribution of Policies With Limits	Percent of Employees in Survey			
< $1,000,000	0%	0%	0%	0%
$1,000,000 - $1,999,999	0%	0%	0%	9%
$2,000,000 - $2,999,999	3%	*	4%	2%
$3,000,000 - $4,999,999	2%	*	4%	3%
$5,000,000 +	95%	100%	92%	86%
Lowest Offered	$2,000,000	$2,000,000	$2,000,000	$250,000
Highest Offered	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Average Purchased	$4,875,045	$4,992,106	$4,793,935	$4,517,261

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

TABLE 23. PRESCRIPTION DRUG COPAYMENTS, SMALL GROUP MARKET, 2008				
	Percent of Employees in Survey			
Prescription Drug Copayment Information	HSA/HDHP	HRA	PPO	HMO/POS
Percentage of Policies With Generic Copayment	14%	89%	83%	98%
Lowest Offered	$4	$4	$5	$5
Highest Offered	$20	$30	$60	$60
Average Purchased	$13	$11	$12	$13
Percentage of Policies with Preferred Brand-Name Copayment	14%	89%	81%	98%
Lowest Offered	$20	$20	$10	$10
Highest Offered	$40	$45	$60	$60
Average Purchased	$17	$31	$29	$30
Percentage of Policies with Non-Preferred Brand-Name Copayment	8%	89%	67%	89%
Lowest Offered	$30	$10	$10	$10
Highest Offered	$70	$75	$100	$100
Average Purchased	$32	$50	$42	$47

Source: America's Health Insurance Plans.

V. 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 2008.

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 was 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 1.2 of the 2008 Kaiser Family Foundation (KFF) employer health benefits survey. The KFF data on family premiums are for a family of four.

VI. 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, based on earlier methodological assistance from Tom Wildsmith, FSA, MAAA, of the Hay Group.

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