AAHP-HIAA

Individual Health Insurance: Wide Choice of Benefits Available

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INTRODUCTION

The individual medical expense insurance market is a vital source of coverage for millions of Americans who do not have access to employer-sponsored health coverage. One of the most common criticisms leveled against individually purchased health insurance policies is that the benefits provided are inadequate. However, very little concrete data exist on the benefit levels prevailing in this market.

Recent research either has focused solely on the range of products offered for sale[i] – not what consumers actually choose to buy – or has been based on limited data from on-line distributors.[ii] More complete information is needed to help policymakers, researchers, and the public better understand the kinds of coverage available in the individual major medical market, and what benefits consumers in that market typically choose to buy.

In July of 2003, the then-Health Insurance Association of America (HIAA) asked member companies active in the individual health insurance market to provide detailed data on the benefits provided under policies and certificates sold during the 12-month period ending on March 31, 2003. (HIAA has since merged with the American Association of Health Plans to form AAHP-HIAA). We limited data collection to policies that meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of "creditable coverage"—guaranteed renewable major medical coverage, but not short-term, limited-benefit, or Medicare supplement coverage. We asked companies to include 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 was designed to provide a level of detail on individual market benefits comparable to that available for employer-sponsored benefits.

Policies Sold During Study Period

	Single		Family	
PPO	388,061	71.4%	140,644	47.4%
Indemnity	135,812	25.0%	136,913	46.1%
MSA	10,373	1.9%	14,715	5.0%
HMO	8,940	1.6%	4,464	1.5%
Total	543,186	100%	296,736	100%

Data were gathered for the 12-month period ending on March 31, 2003.

SUMMARY OF RESULTS

Eleven companies responded with data on 543,186 single policies and 296,736 family policies actually sold to consumers.[iii] Assuming an average of 3.2 persons per family,[iv] this represents almost 1.5 million insured individuals:[v] or 15 percent of the approximately 10 million people in the individual market[vi] – and a much higher percentage of the new policies sold during the study period.[vii]

Based on this study, the "typical" policy purchased by consumers in the individual health insurance market is a PPO plan with a deductible between $750 and $2,000, an annual out-of-pocket limit between $3,000 and $7,500, a lifetime maximum benefit from $2 to $5 million, a co-payment based prescription drug benefit, and coverage for inpatient and outpatient mental health, inpatient and outpatient substance abuse, annual Ob/Gyn visits, well-baby care, and complications of pregnancy. It is important to note, however, that this market offers consumers a wide variety of products.

These survey data are consistent with prior research showing that the majority of consumers in the individual market are in preferred provider organization (PPO) plans.[viii] Many are also in indemnity plans, but the line between PPO products and indemnity products can be blurry.[ix]

Fewer consumers are in health maintenance organization (HMO) plans. The low proportion of HMO policies in these survey data may be partly attributable to the particular companies participating. Nonetheless, the lower prevalence of HMO coverage, compared to PPO/Indemnity coverage and to HMO prevalence in the group market, is also consistent with prior research.[x] Finally, MSA plans represented roughly 2 percent of single policy sales, and 5 percent of family policies sold – the higher percentage for family policies is perhaps surprising, given the expectation of many that MSAs would be most attractive to affluent young singles. Many attribute the overall low prevalence of MSA plans in the market to the statutory restrictions placed on them.

With the exception of MSA products, which are tightly constrained by federal law, each product type was available with a wide range of benefit levels.[xi] PPO plans were not only the most common product type, but were used to provide everything from low-deductible coverage to very high-deductible, catastrophic coverage. While the data are limited, HMO plans appeared to be evenly split between those offering first dollar or low-deductible coverage (below $250), and those with moderately high deductibles ($1,001 - $1,500). Virtually all (99 percent) of the PPO, MSA, and HMO plans sold provided lifetime benefits that exceed $1 million. In addition, all the PPO, HMO and MSA policies in the survey included a limit on annual out-of-pocket expenses.

Almost all policies gave consumers the option of buying prescription drug coverage, most often as a co-payment based benefit, and the majority of consumers chose to include drug coverage in their policies. Eight out of ten indemnity plans (78 percent) covered prescription drugs on a co-payment basis, as did three out of four individual PPO plans (75 percent) and eight out of ten family PPO plans (82 percent). All of the HMO plans in the survey covered drugs on a co-payment basis.

The situation is more complicated for indemnity plans. There appears to be an important market division among indemnity plans. The indemnity plans sold by most carriers look very similar to the PPO plans sold by those same carriers. However, the pattern is significantly different for one large carrier that primarily sells indemnity plans. This carrier's products appear to be used primarily to provide basic coverage at an attractive price. While the deductible levels are somewhat higher than is typical for PPO plans, the most significant differences appear in the lifetime maximum benefit and annual out-of-pocket limit. Even though indemnity plans with maximum benefits of up to $2 million are offered, nine out of ten indemnity plans purchased from

this carrier have benefit maximums of $1 million or less. These are almost evenly split between those with maximums of $750,001 to $1 million, and those with maximums of $250,000 or less. While some of the products sold by this carrier include out-of-pocket limits, most do not.

DEDUCTIBLES

A wide variety of deductible levels are available, particularly for PPO and indemnity plans. PPO products are available with first dollar coverage, and indemnity products are available with deductibles as low as $100. Most consumers do not choose to buy low-dollar coverage, however, and many insurers' product offerings reflect this. For many companies, the lowest deductible offered was $500.

Every company reporting PPO data offered deductibles as high as $5,000, and most as high as $10,000. Results were similar for indemnity products, although one company with sales of 160 indemnity policies reported a maximum deductible of $2,500.

Deductibles in MSA plans are constrained by federal law.[xii] The highest reported deductible offered by an HMO plan was $1,500.

With the notable exception of HMO programs, which are historically designed to provide first-dollar coverage, very few consumers in the individual market buy policies with deductibles of $250 or less. And relatively few consumers buy policies with deductibles greater than $3,000 (except for family coverage under an MSA, where federal law requires a higher deductible). But the minority of consumers buying policies with deductibles of $3,000 or more is large enough to raise the average deductible: almost half of all single PPO policies (49 percent) have deductibles of $1,000 or less, yet the average deductible is roughly $1,500.

With the exception of MSA plans, the deductible levels given for family policies in the table on this page are the deductibles applied to each individual family member covered by the plan. Most policies also had a "family deductible limit" on either the number of deductibles,

Distribution of Policies by Deductible Level

	Single				Family			
	Ind.	**MSA**	**PPO**	**HMO**	**Ind.**	**MSA**	**PPO**	**HMO**
<= $250	0.14%		2.66%	36.05%	0.06%		1.27%	50.53%
$250 - $500	1.18%		18.34%		0.20%		11.02%	
$501 - $750	0.01%		2.82%				0.90%	
$751 - $1,000	34.92%		24.90%		27.17%		23.5%	
$1,001 - $1,500	9.24%		11.65%	63.95%	9.83%		13.96%	49.47%
$1,501 - $2,000	11.60%	29.65%	16.39%		12.74%		17.27%	
$2,001 - $3,000	32.77%	70.34%	15.11%		37.35%		22.34%	
$3,001 - $4,000	0.99%		0.48%		1.11%	38.11%	0.51%	
$4,001 - $5,000	7.52%		7.11%		8.52%	61.32%	8.39%	
$5,001 +	1.63%		0.53%		2.01%	0.58%	0.81%	
Lowest	$100	$1,650	$0	$0	$100	$3,300	$0	$0
Highest	$10,000	$2,500	$10,000	$1,500	$10,000	$5,050	$10,000	$1,500
Average	$2,229	$2,064	$1,535	$959	$2,409	$4,128	$1,827	$742

or on the total dollar amount of deductibles paid by the family as a whole. We did not request data on family deductible limits. An MSA-qualified family policy must apply, by federal law, a single deductible to the combined expenses of all family members covered.

Consumers purchasing family coverage tended on average to choose deductibles a few hundred dollars higher than did those purchasing single coverage. HMO plans appear to be an exception to this rule; perhaps those families attracted to HMO programs also tend to be attracted to first-dollar coverage.

There is some danger in focusing on average deductible levels – it may tend to obscure the diversity of the market. Very low deductibles are available, and while relatively few consumers choose to purchase them, some do. At the other extreme, deductibles as high as $10,000 are available, and some consumers choose very high deductibles. While a $2,000 deductible may be "typical," the market contains everything from first-dollar coverage to catastrophic plans with deductibles in excess of $5,000.

PPO plans vary in their treatment of deductibles. Some apply a single deductible to both in-network and out-of-network expenses. Others have separate in-network and out-of-network deductibles. The survey asked for the deductible level applicable to in-network and out-of-network expenses; it does not distinguish between the two different approaches, however. For single coverage, the average PPO deductible for in-network expenses was $1,535; the average deductible for out-of-network expenses was $1,702. This likely represents a mix of different approaches, but does suggest that it is relatively common to use deductibles to encourage the use of network providers.

OUT-OF-POCKET LIMITS

An important measure of the financial protection provided by a medical expense policy is the amount of out-of-pocket expense an individual is exposed to during a year. This survey defines the annual out-of-pocket limit as the maximum amount an insured individual will pay in deductible expenses and coinsurance during a year.

Limits on out-of-pocket spending are a routine feature in the individual market, except for HMO plans that have no deductible or coinsurance. As with deductibles, a wide range of out-of-pocket limits is available – some as low as $250 – but most consumers purchase limits in the broad middle range between $1,501 and $7,500. Roughly two-thirds of PPO plans are sold with annual out-of-pocket limits between $3,001 and $7,500 (more than half fall between $3,001 and $5,000). Relatively few consumers choose limits higher than this.

As with deductibles, the out-of-pocket limits reported here for family policies are those applied to each individual family member covered by the plan. Most policies also have a "family out-of-pocket limit" on either the number of deductibles, or on the total dollar amount of deductibles paid by the family as a whole. We did not request data on family out-of-pocket limits. Again, MSA plans are an exception – MSA-qualified policies combine the expenses for all family members before applying deductibles, coinsurance, and out-of-pocket limits.[xiii]

With the exception of MSA products, consumers buying single policies and those buying family policies generally choose roughly comparable out-of-pocket limits.

While out-of-pocket limits average $2,800-$3,700 for indemnity and PPO plans, a significant number have limits of $2,000 or less, and greater than $4,000.

Distribution of Policies by Out-of-Pocket Limit

	Single				Family			
	Ind.	**MSA**	**PPO**	**HMO**	**Ind.**	**MSA**	**PPO**	**HMO**
<= $1,000	2.95%		1.71%	22.39%	1.47%		0.74%	44.85%
$1,001 - $1,500	2.96%		3.11%		2.60%		2.36%	
$1,501 - $2,000	49.48%	28.97%	16.86%		29.36%		13.22%	
$2,001 - $2,500	12.88%	24.92%	5.49%		17.39%		6.75%	
$2,501 - $3,000	5.01%	34.18%	6.14%	77.61%	4.59%		4.63%	55.15%
$3,001 - $4,000	10.85%	11.93%	23.92%		18.56%	36.85%	27.85%	
$4,001 - $4,000	10.13%		26.59%		15.82%	51.30%	38.32%	
$5,001 - $7,500	4.15%		15.30%		7.48%	11.85%	5.51%	
$7,501 - $10,000	1.16%		0.72%		2.23%		0.43%	
$10,000 +	0.39%		0.17%		0.58%		0.19%	
Lowest	**$250**	**$1,650**	**$250**	**$0**	**$250**	**$3,300**	**$250**	**$0**
Highest	**$13,000**	**$3,350**	**$16,000**	**$3,000**	**$13,000**	**$6,150**	**$16,000**	**$3,000**
Average	**$2,834**	**$2,535**	**$3,630**	**$2,328**	**$3,434**	**$4,541**	**$3,649**	**$1,655**

COINSURANCE

Once the deductible has been satisfied, many policies require the insured to pay a percentage of his or her costs—called coinsurance—until the annual out-of-pocket limit is reached. The coinsurance percentage for an individual policy can vary from zero (no coinsurance) to 50 percent. (Many network-based plans use co-payments for in-network office visits, and coinsurance for out-of-network visits; co-payment levels will be discussed in the next section.)

With indemnity plans, 20 percent coinsurance appears to be the norm. The average coinsurance percentage was significantly lower for both MSA and HMO plans. For HMOs, this is likely due to a reliance on co-payments as an alternative form of cost sharing (note that HMOs only offer coinsurance levels of 20 percent and lower). For MSA plans, the relatively narrow corridor between the allowable deductible levels and allowable out-of-pocket levels may limit the value of coinsurance provisions, as they would be applied to relatively few expenses.

Coinsurance is the primary tool used by PPO plans to encourage use of network providers; on average the in-network coinsurance level is about 20 percentage points lower than the out-of-network coinsurance level. In addition, out-of-network use is subject to balance billing, providing consumers with a significant incentive to use network providers.

Coinsurance Levels

	Single			Family		
	Ind.	**MSA**	**HMO**	**Ind.**	**MSA**	**HMO**
Lowest	0%	0%	0%	0%	0%	0%
Highest	50%	50%	20%	50%	50%	20%
Average	20%	14%	16%	20%	8%	11%

PPO Coinsurance Levels

	Single		Family	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lowest	0%	20%	0%	20%
Highest	50%	70%	50%	70%
Average	24%	43%	26%	44%

OFFICE VISIT CO-PAYMENTS

Office visit co-payments have become a common form of cost sharing (except among MSA products, which are prohibited by federal law, with a narrow exception for state-mandated preventive care benefits, from providing coverage below the minimum required deductible level). Office visit co-payments can encourage use of primary care physicians rather than other care settings, and encourage use of network physicians.

Office visit co-payments were not markedly more prevalent among HMO policies than among PPO or indemnity policies. This is due to a substantial number of high-deducible HMO policies in the sample.

Office Visit Co-Payments								
	SINGLE				FAMILY			
		PPO				PPO		
	Ind.	In-Net	Out	HMO	Ind.	In-Net	Out	HMO
Included	61%	64%	33%	22%	60%	55%	23%	45%
Lowest	$0	$0	$30	$30	$0	$0	$30	$30
Highest	$25	$50	$65	$30	$25	$50	$30	$30
Average	$12	$26	$30	$30	$13	$26	$30	$30
< $10	46%				43%	1%		
$10<$15		5%				6%		
$15<$20	54%	2%			57%	7%		
$20<$25		22%				17%		
$25<$30		10%				16%		
$30+		60%	100%	100%		53%	100%	100%

LIFETIME MAXIMUM BENEFITS

Another important measure of the level of catastrophic protection provided by a policy is the lifetime maximum benefit. Every carrier submitting data offers lifetime benefits up to $2 million—most offer coverage up to $5 million. Several offer unlimited benefits. In the case of HMO plans, all of the policies sold had unlimited maximum benefits. While, relatively few consumers purchasing other types of plan chose policies with unlimited benefits, the vast majority of PPO and MSA policies purchased provided at least a $2 million dollar maximum benefit, and average $4-$5 million.

As mentioned above, the exception to this pattern is with indemnity plans. While maximum benefits of at least $2 million are available from all of the companies reporting indemnity plan data, a substantial number of indemnity policies had maximums of $1 million or less. It appears that these plans are used to provide low cost, basic protection.

Since there should be no appreciable difference in premium between a plan with a $3 million dollar maximum benefit and an unlimited benefit, it is unclear why consumers are choosing plans with limits. Perhaps the commitment to provide a very high, albeit limited, level of benefits (e.g., "We promise to pay up to $5 million.") simply has more psychological weight than does an unlimited benefit, which has no concrete dollar value attached. Alternatively, policies providing unlimited benefits may tend to include other high-cost benefits

Distribution of Policies by Lifetime Maximum Benefit

	Single				Family			
	Ind.	**MSA**	**PPO**	**HMO**	**Ind.**	**MSA**	**PPO**	**HMO**
Unlimited	0%	5%	1%	100%	0%	1%	1%	100%
Plans with Limits								
Lowest	$100,000	$2,000,000	$250,000		$100,000	$2,000,000	$250,000	
Highest	$6,000,000	$8,000,000	$8,000,000		$6,000,000	$8,000,000	$8,000,000	
Average	$773,133	$5,036,533	$4,855,706		$674,877	$5,454,059	$3,521,297	
<= $250,000	43%				43%			
$250,001 - $500,000								
$500,001 - $750,000								
$750,001 - $1,000,000	49%				52%			
$1,000,001 - $2,000,000	4%		3%		4%		7%	
$2,000,001 - $5,000,000	3%	68%	89%		1%	52%	76%	
over $5,000,000	1%	32%	8%		1%	47%	17%	

that raise premium rates, or carriers whose products include a specific limit may have stronger brand recognition or be appealing to consumers for other reasons.

For most people, there is little practical difference in the protection provided by an unlimited maximum benefit and one limited to several million dollars. In 1996, the one percent of Americans with the highest health care expenses spent on average only $56,459 annually.[xiv] This is consistent with the results of the Society of Actuaries' large claims study, which examined data on health insurance claims in excess of $25,000 from 1991-92. Average medical charges per claimant averaged roughly $58,000, and the sub-sample for which exposure data were available suggested that the incidence of these large claims was 1 percent. Among the roughly 0.05 percent of these high cost claimants with charges in excess of $1 million, the average charge was approximately $1.5 million.[xv] Very few individuals are likely to have expenses in excess of a million dollars, and even those few do not have costs running into tens of millions of dollars.

DRUG COVERAGE

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 program 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. Some significant differences may be seen between the different types of products.

Drug cards are a very popular feature for all non-MSA products. Virtually all indemnity, PPO, and HMO plans are purchased from carriers offering a drug card, and most consumers elect to buy the drug card. With MSA plans, however, prescription drugs are almost always treated as any other medical expense.

The use of co-payments is universal among drug-card plans. There is a fair degree of uniformity in the range of co-payments offered, as well as the average level of co-payments for the various different product types. The co-payment for generic drugs most often falls in the $10-$20 range, averaging $10-$11, while the co-payment for brand-name drugs generally falls in the $20-$45 range, averaging $25-$32.

Type of Drug Coverage

			PPO		HMO	
	Ind.	MSA	Single	Family	Single	Family
"Integrated"						
Offered	2%	100%	11%	9%	0%	0%
Purchased	1%	100%	3%	2%	0%	0%
Drug Card						
Offered	98%	3%	100%	100%	100%	100%
Purchased	78%	2%	75%	82%	100%	100%

Drug Card Co-Payments

	Indemnity		PPO		HMO	
	Gen.	Brand	Gen.	Brand	Gen.	Brand
Lowest	$10	$20	$0	$0	$10	$25
Highest	$20	$40	$20	$45	$25	$45
Average	$11	$32	$10	$26	$10	$25

SPECIFIC BENEFITS

This survey asked companies whether they offered a variety of specific benefits with their individual market products, and how many of their customers chose to purchase them. In many cases, these benefits are offered as an additional cost option. In others, they are provided as a standard feature of the plan.

It is important to note that the survey only measures whether or not some level of benefits is provided for a particular category of expense; it does not attempt to measure the extent of coverage provided. In many cases, there may be limits on the number of services provided, dollar amount of benefits provided, or special cost sharing requirements.

It is important to distinguish between the various maternity-related expenses. Coverage for pre-natal care and the normal expenses associated with delivery are typically offered as optional benefits. Complications of pregnancy – such as preeclampsia, ectopic pregnancy, or gestational diabetes – are treated as any other illness.

Specific Benefits

	SINGLE				FAMILY			
	Ind.	**MSA**	**PPO**	**HMO**	**Ind.**	**MSA**	**PPO**	**HMO**
Percentage of Buyers Offered Selected Benefit								
Inpatient Mental Health	100%	100%	99%	100%	100%	100%	100%	100%
Outpatient Mental Health	100%	94%	84%	100%	100%	96%	92%	100%
Annual Ob/Gyn Visit	98%	94%	85%	100%	100%	96%	92%	100%
Adult Physicals	98%	91%	63%	100%	100%	95%	68%	100%
Well-Baby Care	98%	100%	99%	100%	100%	100%	100%	100%
Inpatient Substance Abuse	98%	98%	99%	100%	100%	99%	99%	100%
Outpatient Substance Abuse	98%	92%	80%	100%	100%	95%	87%	100%
Pre-Natal Care	99%	93%	97%	100%	100%	95%	90%	100%
Normal Delivery	100%	58%	62%	100%	100%	83%	72%	100%
Complications of Pregnancy	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of Buyers Purchasing Selected Benefit								
Inpatient Mental Health	98%	100%	93%	100%	99%	100%	96%	100%
Outpatient Mental Health	98%	94%	78%	100%	99%	96%	88%	100%
Annual Ob/Gyn Visit	51%	94%	75%	100%	74%	96%	82%	100%
Adult Physicals	51%	91%	58%	100%	74%	95%	63%	100%
Well-Baby Care	53%	100%	88%	100%	75%	100%	89%	100%
Inpatient Substance Abuse	59%	98%	93%	100%	81%	99%	96%	100%
Outpatient Substance Abuse	49%	93%	73%	100%	72%	95%	83%	100%
Pre-Natal Care	48%	42%	65%	100%	39%	19%	55%	100%
Normal Delivery	48%	7%	32%	100%	39%	7%	31%	100%
Complications of Pregnancy	100%	100%	100%	100%	100%	100%	100%	100%

The results shown are weighted by the number of policies sold during the study period. One large contributor reported offering all of the benefits under study, but was unable to report the percentage of their customers who chose each option – we excluded their data when calculating the overall percentage of customers choosing to purchase these benefits. The values reported for PPO and HMO plans are based on the benefits provided in-network.

The benefits studied are generally widely available. While our HMO data are somewhat limited, 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 almost all of the policies purchased. Substance abuse coverage is somewhat less common, particularly among indemnity plans. Indemnity plans are also least likely to include preventive care, which would be consistent with their use as basic, low-cost forms of protection. MSA products generally include preventive care, though most routine expenses are likely funded through the savings account.

It appears that routine maternity-related benefits (prenatal care and normal delivery) are among those consumers are most likely to consider optional. This may be due to the relatively predictable nature of pregnancy. Consumers purchasing MSA products are least likely to buy maternity benefits; this may suggest an expectation of paying maternity costs out of the associated savings account.

It is important to note, however, that all of the policies surveyed provided coverage for complications of pregnancy (this is generally done through the policy's definition of "sickness," rather than as a separate benefit). Similarly, state insurance codes require insurers to cover newborns from birth, if they are added to a parent's policy within 30 days after delivery.

MEDICAL-MANAGEMENT PROGRAMS

Three of the most common ways in which carriers help manage the cost of health care (and, in turn, the cost of health insurance coverage) are: utilization review/utilization management; case management; and disease management. Carriers were asked which programs they made available with each product type. The results were weighted by the number of policies.

Case management programs are ubiquitous. Utilization review is quite common, with the notable exception of carriers offering indemnity plans and with HMOs. With HMOs, other structural controls on utilization may lessen the need for separate utilization review programs.

Indemnity plans appear to make very little use of either utilization review or disease management. Presumably, this is due to either the structure of the programs or their positioning in the market.

Almost all MSA plans reported using utilization review, perhaps for services covered beyond the deductible.

Medical-Management Programs

			PPO		HMO	
	Ind.	**MSA**	**Single**	**Family**	**Single**	**Family**
Utilization Review	4%	97%	73%	69%	22%	45%
Case Management	100%	100%	99%	100%	100%	100%
Disease Management	2%	45%	76%	61%	100%	100%

COMPARISON WITH PRIOR RESEARCH

We believe this survey to be the largest and most comprehensive study of individual market benefit levels ever conducted. Other researchers, however, have addressed the same question. The on-line health insurance distributor eHealthInsurance has released a series of reports based on individual medical expense insurance policies purchased through their website.[xvi] The eHealthInsurance reports are based on a smaller sample size and a single distribution channel, but include policies from a variety of health insurers.

The eHealthInsurance results show a very different distribution of policies by product type. PPO coverage is even more dominant. Most significantly, indemnity coverage is much less prevalent in the eHealthInsurance data. HMO/POS coverage is much more prevalent, although it still represents only 10-15 percent of the total.

The deductible levels reported by eHealthInsurance are on average much lower than those in the HIAA data. In particular, eHealthInsurance reports significantly more plans with deductibles of $500 or less, and fewer with deductibles between $1,000 and $3,000.

Distribution of Policies by Type Reported by eHealthInsurance

	June 2001	Feb. 2002	Sept. 2002
PPO	75%	78%	80%
HMO	16%	10%	11%
Indemnity/Other	5%	11%	9%
POS	2%		
MSA	1%		
Total	100%	100%	100%

The June 2001 data are based on both single and family policies; the 2002 data are based on single policies only.

The cause of this difference in deductible levels is not clear. Using the Internet to purchase health insurance may attract a group of consumers who, due to income, education, age, or other factors, find lower deductibles particularly attractive. Alternatively, the structure of the distribution channel may affect the type of policies consumers select. When first presenting alternative plans, eHealthInsurance highlights the deductible, coinsurance, office visit co-payment, premium, plan type (e.g., indemnity vs. PPO), and carrier A.M. Best rating. Consumers using eHealthInsurance may as a result tend to look for the lowest deductible, coinsurance, and co-payment for the price they are willing to pay, and give relatively less weight to other plan features. Consumers working with an agent may be more likely to accept a higher deductible in exchange for a broader network of providers, a lower out-of-pocket limit, a higher maximum benefit, or some other expansion of coverage.[xvii]

Jon Gabel and colleagues have contrasted individual health insurance with employer-sponsored coverage.[xviii] They studied policies offered for sale – not policies actually purchased – by the Internet distributors eHealthInsurance and QuoteSmith. Thus, while their study provides some information on the policies available to consumers through the Internet, it does not provide any information about the coverage they actually have.

As with the eHealthInsurance reports, the Gabel study reports average deductibles of $1,440 for indemnity plans, $1,897 for PPO and POS plans, and $0 for HMO plans – lower than what we found for indemnity and for HMO plans, but somewhat higher than our result for PPO plans.[xix] These results represent an average among the policies offered for sale; perhaps it is not surprising that the averages are of the same general magnitude as – but not equal to – those among the policies consumers actually purchase.

The Gabel study also examined annual out-of-pocket limits. However, instead of reporting the distribution of policies by out-of-pocket limit, or the average out-of-pocket limit, it reported only the percentage of plans with limits of $2,000 or less. This tends to obscure the ubiquity of out-of-pocket limits among PPO, MSA, and HMO plans (and employer-sponsored programs). It also obscures the relationship that consumers appear, on average, to maintain between deductibles and out-of-pocket limits.

Distribution of Policies by Deductible Reported by eHealthInsurance

	June 2001	Feb. 2002	Sept. 2002
$500 or less	47%	43.5%	43.8%
$501 - $1,000	25%	25.9%	22.8%
$1,001 - $1,500	7%	7.5%	7.7%
$1,501 - $2,000	6%	7.8%	9.9%
$2,001 - $3,000	10%	10.0%	10.4%
Over $3,000	5%	5.3%	5.5%
	100%	100%	100%

The June 2001 data are based on both single and family policies; the 2002 data are based on single policies only.

The prevalence of inpatient mental health coverage, outpatient mental health coverage, and well-baby care reported by the Gabel study are also significantly lower than we found – particularly for indemnity plans. The prevalence of drug coverage was comparable, except for indemnity plans, where again the result was well below what we found.

More recently, Jill Yegian, Susan Marquis and colleagues analyzed enrollment information from the three largest carriers in the California individual health insurance market.[xx] Their results suggest that HMO coverage is significantly more prevalent in California (37 percent), deductibles are somewhat lower (averaging $1,099 in 2002), and out-of-pocket limits are about the same as the rest of the country (averaging $4,219 for PPOs in 2002). Almost nine out of ten (87 percent) of plans provided drug coverage. Perhaps most significantly, the California study included data for the period 1997 through 2002, and concluded that "[d]espite concerns about increased consumer cost sharing, the average share of health spending covered by these products has remained constant between 1997 and 2002."

What do these results suggest? Not surprisingly, on average the products offered for sale appear to mirror those that consumers actually choose to buy. As is the case with other individually purchased insurance products such as automobile and homeowners insurance, many consumers balance coverage needs against available funds by choosing a higher deductible than the average available in the market in exchange for broader coverage. It appears that consumers buying health insurance over the Internet choose lower deductibles than those purchasing through other distribution channels.

COMPARISON WITH THE GROUP MARKET

Commentators and researchers alike often use the benefits provided by employer-sponsored health plans as a benchmark for evaluating the benefits provided by individually purchased health insurance. There are a number of difficulties with such comparisons.[xxi] Perhaps the most basic is that employer-provided health benefits are a form of untaxed compensation, while in the individual market consumers must pay premiums directly out of their own pockets. As a result, the economic incentives affecting the amount of coverage purchased are very different in these two markets. Yegian, Marquis and colleagues noted, "coverage provided by group products is not a gold standard."

Nonetheless, comparisons between the benefits selected by consumers in the individual market, and those provided by employers, are routinely made. Rather than recognizing the role of consumer choice, and the differing needs of purchasers in the two markets, these comparisons are often used to suggest that individual coverage provides inadequate financial protection to consumers. A careful examination of the data, however, demonstrates that the individual market can meet a wide variety of consumer needs, allowing buyers to strike their own balance between cost and coverage.

A broad range of products is available in the individual market, including everything from HMO plans to traditional indemnity plans. Three significant differences between the individual market and employer-sponsored plans are the much higher prevalence of indemnity plans; the prevalence of MSA plans; and the smaller market-share of HMO and POS plans.

Benefit levels comparable to those provided by the typical employer are also available in the individual market – and some consumers choose to purchase them. Most do not. Other than maternity-related benefits, the most notable differences between coverage purchased in the individual market and that provided by the typical employer is in the cost-sharing provisions, rather than in the scope of coverage provided.

Deductibles in the individual market are, on average, significantly higher than those in employer-sponsored programs. Without an employer subsidy, consumers in this market are directly responsible for the entire cost of coverage. In addition, while employer contributions to health benefit plans are not taxable to employees, many purchasers in the individual market are unable to deduct their premiums.

Average Deductible Levels - 2003

	Individual		Group	
	Single	Family	Single	Family
Indemnity	$2,229	$2,409	$384	$785
PPO	$1,535	$1,827	$275	$561
HMO	$959	$742	$113	$442

Group market data taken from *Employer Health Benefits: 2003*, The Henry J. Kaiser Family Foundation, September 2003.

Annual out-of-pocket limits are also commensurately higher in the individual market. This is unsurprising – since because the deductible is one component of the out-of-pocket liability, when a consumer raises his or her deductible, it is natural to consider a higher out-of-pocket limit at the same time. It appears that an out-of-pocket limit between $1,000 and $2,000 would be typical for employer-sponsored coverage – or roughly two to seven times an average deductible. Our survey data show average individual market out-of-pocket limits that are approximately one-and a half to two-and-a-half times the average deductible level. (MSA plans are an exception – the maximum out-of-pocket limits are constrained by federal statute to what appear to be artificially low levels.) This suggests that consumers are making consistent risk-management decisions when selecting deductibles and out-of-pocket limits. If any-

thing, the relatively modest ratio between the two may suggest that consumers in the individual market are somewhat more willing to accept higher deductibles than higher out-of-pocket liability.

In general, lifetime maximum benefits in the individual market are comparable to those provided by employer-sponsored health plans. All of the HMO policies in the survey had unlimited maximum benefits. While unlimited maximums are available with other product types, relatively few consumers choose them. Consumers buying PPO and MSA products overwhelmingly choose lifetime maximums of $2 million or more, and average $3.5 to $5.5 million.

Lifetime Maximum Benefits in Employer-Sponsored Plans - 2002

	Ind.	PPO
<= $250,000	1%	2
$250,0010 - $999,999	1%	3%
$1 million +	42%	62%
Unlimited	29%	24%
Unknown	26%	9%

Values for single coverage Data taken from *Employer Health Benefits: 2002*, The Henry J. Kaiser Family Foundation, September 2002. Data on lifetime maximum benefits were not included in the 2003 report.

Out-of-Pocket Limits in Employer-Sponsored Plans - 2002

	Ind.	PPO
<= $999	25%	17%
$1,000 - $1,499	26%	24%
$1,500 - $1,999	16%	18%
$2,000 - $2,499	7%	13%
$2,500 - $2,999	2%	7%
$3,000 +	7%	11%
No Limit	6%	5%
Unknown	12%	6%

Values for single coverage. Data taken from *Employer Health Benefits: 2002*, The Henry J. Kaiser Family Foundation, September 2002. Data on out-of-pocket limits were not included in the 2003 report.

As noted above, a substantial number of consumers appear to be using indemnity plans with no out-of-pocket limit and comparatively low maximum benefit levels (between $100,000 and $250,000) to provide basic, low-cost protection. While this is not unknown among employer-sponsored plans, it is much less common. The difference likely reflects greater price-sensitivity among consumers in the individual market. Those individuals who are reasonably confident that they will not fall into the 5 percent or so of the population with the highest medical expenses may not see any need for very high benefit guarantees. In states that allow medical underwriting and rely on another mechanism, such as a high-risk pool, to guarantee access to coverage, this may include most new purchasers – although any consumer entering the health insurance market presumably does so at least in part because of the risk of future illness or injury. Alternatively, consumers who expect to return to the workforce or become eligible for Medicare with a year or so may be using these low-maximum benefit policies as a source of transitional coverage.

IMPLICATIONS FOR MSAs/HSAs

While proponents of the MSA/HSA concept sometimes speak of the associated “high deductible health plans” as if they represented a new, innovative type of catastrophic health insurance, both indemnity and PPO policies are available with deductibles higher than those allowed by the federal MSA-enabling legislation – and a significant number of consumers are purchasing those high-deductible indemnity and PPO policies.

This, in conjunction with the much greater prevalence of indemnity and PPO plans than MSA plans, suggests that most consumers choosing deductibles of $1,500 or more are not doing so because of the tax breaks made available by the MSA statute. Nine out of ten consumers buying high-deductible coverage are choosing something other than an MSA plan – perhaps because of other limitations associated with MSA plans.

Examining the distribution of family plans by deductible, it is also clear that the current requirement that to be MSA qualified a plan must apply a single deductible to all expenses for a family seriously distorts the market. Consumers purchasing family coverage that is not MSA-qualified consistently choose plans that apply a separate deductible to each family member, and that deductible is generally comparable in size to that typical for single coverage.

The situation for out-of-pocket limits is similar. For single coverage, the out-of-pocket limit for MSA plans averages about half that for indemnity and PPO plans, even though the average deductibles are comparable. In fact, the average deducible for MSA plans is closer to that for HMO coverage. For family coverage, the average out-of-pocket limit is comparable to that for indemnity and PPO coverage, even though the average deductible is roughly twice that for indemnity and PPO plans. These results suggest that the out-of-pocket limits allowed by the Archer MSA statute are much too low relative to the allowable deductible levels.

The HSAs established by the recently enacted Medicare reform bill are intended to supercede the existing MSA pilot program. The HSA legislation significantly expands the allowable range of deductible and out-of-pocket amounts, expands eligibility, and liberalizes the MSA rules in other ways. It seems likely that HSAs will be attractive to more consumers than MSAs have been in the past.

CONCLUSIONS

A wide range of products is available in the individual health insurance market, including some with very low deductibles and out-of-pocket limits. Very high deductibles are also available. On average, consumers in the individual market choose deductibles higher than are typical among employer-sponsored programs, with most falling between $750 and $3,000. Out-of-pocket limits are proportionately higher also. Lifetime maximum benefits of $2 million or more are typical. Indemnity plans represent an exception to this general pattern; it appears that a significant number of consumers are choosing indemnity plans with no out-of-pocket limit and comparatively low maximum benefit levels as a form of basic protection.

Most consumers choose to purchase prescription drug coverage. A range of optional benefits is available (some of which are required in particular states). Mental health coverage is provided by most policies. Maternity-related benefits appear to be among those that consumers are most likely to decline.

While products mirroring employer-sponsored health benefit programs are available, they are not what most consumers in the individual market choose to buy. This is not surprising, given the lack of an employer subsidy and the less favorable tax treatment faced by many. Consumers in this market appear to be making reasonable risk management decisions as they allocate limited premium dollars, reducing premiums with higher deductibles and out-of-pocket limits while maintaining maximum benefit levels adequate to deal with catastrophic claims.

ENDNOTES

i Jon Gabel et al., "Individual Insurance: How Much Financial Protection Does It Provide?" Health Affairs Web Exclusive, April 17, 2002; Insurance Markets: Individuals Find Wide Price Spreads and Differing Benefits When Shopping for Insurance, California HealthCare Foundation, November 2002.

ii Vip Patel, Analysis of National Sales Data of Individual and Family Health Insurance, eHealthInsurance, Sunnyvale, CA, June 2001; The Cost and Benefits of Individual Health Insurance Plans, Fact Sheet, eHealthInsurance, September 2002.

iii We sent this survey to all HIAA member companies. Most HIAA members do not sell individual health insurance, and not all that do chose to participate. Participating companies tended to be those for which individual major medical is a primary product line, and included some of the largest carriers in the market. Any response bias is likely towards companies focused on the individual market. We do not believe that this significantly distorts the results.

iv Statistical Abstract of the United States, 2002, Table No. 56, Bureau of the Census, U.S. Department of Commerce.

v The next largest survey of individual market benefit levels, by eHealthInsurance, included data on only 20,000 single policies sold through the eHealthInsurance website.

vi The Census Bureau reports, based on its annual Current Population Survey, that 16.5 million non-elderly Americans have private health insurance that is not based on employment (Robert Mills and Shailesh Bhandari, Health Insurance Coverage in the United States: 2002, U.S. Census Bureau, U.S. Department of Commerce, September 2003 – the 16.5 million is based on the tabulations for non-elderly Americans; the data for seniors primarily represent Medicare Supplement coverage). However, by including short-term and other products besides guaranteed renewable major medical coverage, this overstates the true size of the individual market. Most analysts estimate that 10 million or fewer non-elderly Americans have individually purchased, guaranteed renewable major medical coverage (e.g., Jack Hadley and James D. Reschovsky, Tax Credits and the Affordability of Individual Health Insurance, Issue Brief Number 53, Center for Studying Health System Change, July 2002, and Mark Pauly and Len Nichols, The Nongroup Health Insurance Market: Short on Facts, Long On Opinions and Policy Disputes, Health Affairs web exclusive, October 23, 2002.)

vii Most consumers will not change carriers every year. If 25 percent of the 10 million consumers with individual health insurance policies buy a new policy each year, this sample represents over half (60 percent) of the new policies sold during the study period.

viii We provided survey participants with two specific categories for network-based plans: "PPO" and "POS/HMO." Given the convergence among managed care plans, we did not attempt to specify a single definition of "PPO," "POS," or "HMO," but allowed survey participants to use their own definitions. As it turns out, participants were very consistent in the way they reported data on network-based plans. All of the data reported as "PPO" included out-of-network benefits; none of the data reported as "POS/HMO" included out-of-network benefits.

ix For the category of "Indemnity Plans," survey participants were asked to include all products that are not based on a provider network, other than those intended to be used in conjunction with a Medical Savings Account. In discussing with industry representatives the apparent prevalence of indemnity plans, several noted that carriers in the individual market sometimes offer plans that provide access to PPO network discounts, but make no benefit differential between services provided by in-network and out-of-network providers. The incentive to use network providers comes from the lower negotiated charges, which reduce the out-of-pocket expenses of the consumer. The indemnity data reported may include some of these plans.

x Deborah Chollet et al., Mapping State Health Insurance Markets, 2001: Structure and Change, AcademyHealth, September 2003;
Deborah Chollet et al., Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets, 1995-1997, Academy for Health Services Research and Health Policy, December 2000.

xi The recently enacted Medicare reform bill establishes Health Savings Accounts (HSAs), which are intended to supercede the existing Archer Medical Savings Accounts (MSAs). The legislative constraints on the allowable deductibles and out-of-pocket maximums have been significantly loosened, eligibility has been greatly expanded, and the program liberalized in other significant ways. Because they address many of the limitations of the MSA pilot program, it is likely that HSAs will be attractive to many more consumers.

xii The minimum and maximum deductibles and maximum out-of-pocket limits allowable under MSA-qualified high-deductible health plans are indexed each year. For 2003, the allowable deductibles were $1,700 to $2,500 for single coverage, and $3,350 to $5,050 for family coverage (IRS Revenue Procedure 2002-70). The new HSA enabling legislation specifies a minimum deductible of $1,000 for single coverage and $2,000 for family coverage. The maximum deductible levels are constrained by the maximum allowable out-of-pocket limits of $5,000 for single coverage and $10,000 for family coverage.

xiii For 2003, the maximum allowable out-of-pocket limits for MSA-qualified high-deductible health plans were $3,350 for single coverage and $6,150 for family coverage (IRS Revenue Procedure 2002-70). The new HSA enabling legislation specifies maximum allowable out-of-pocket limits of $5,000 for single coverage and $10,000 for family coverage.

xiv Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," Health Affairs, March/April 2001, pages 9-18.

xv Kyle L. Grazier, Group Medical Insurance Large Claims Database Collection and Analysis: Report for Public Release, Society of Actuaries, May 1996.

xvi Vip Patel, Analysis of National Sales Data of Individual and Family Health Insurance, eHealthInsurance, Sunnyvale, CA, June 2001;
The Cost and Benefits of Individual Health Insurance Plans, Fact Sheet, eHealthInsurance, February 2002;
The Cost and Benefits of Individual Health Insurance Plans, Fact Sheet, eHealthInsurance, September 2002.

xvii eHealthInsurance did not report on out-of-pocket limits, lifetime maximum benefits, or any optional benefits other than prescription drugs. The level of drug coverage, 85 percent, is roughly comparable to that in the HIAA data.

xviii Jon Gabel et al., "Individual Insurance: How Much Financial Protection Does it Provide?" Health Affairs Web Exclusive, April 17, 2002.

xix The Gabel study appears to have examined single coverage only, although there is no reason to believe that the results would have been significantly different had they examined family coverage, since most individual policies other than MSA products may be purchased on either a single or a family basis. The average deductible reported for PPO/POS plans ($1,897) is higher than our value for single coverage ($1,535) but about the same as our value for family coverage ($1,827).

xx Melinda Buntin et al., "Trends and Variability In Individual Insurance Products in California," Health Affairs Web Exclusive, September 24, 2003.

xxi Donald Young and Thomas Wildsmith, "Individual Versus Employer Insurance Markets: Digging Deeper Into The Differences,"

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