

July 2011

# Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits

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## INTRODUCTION

In July 2010, 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 477,000 small groups (those with 50 or fewer employees), reflecting approximately 3.7 million workers and 1.3 million dependents with coverage as of January 2010. Over 70 percent of the small groups represented had 10 or fewer employees. In total, 11 AHIP member companies provided data for the survey, including several large national and regional carriers, as well as single-state and local plans. This survey is an update to AHIP's 2008 survey of the small group market.<sup>1</sup>

## KEY SURVEY RESULTS

- In 2010, the average monthly premium for small group health insurance was \$426 (\$5,107 annually) for single coverage and \$1,117 (\$13,409 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 \$406 per month for single coverage, while firms with between 11 and 25 employees paid an average of \$419 per month for single coverage, and firms with 10 or fewer employees had average monthly premiums of \$446 for single coverage.
- Seventy-three (73) percent of the small groups and 37 percent of the covered lives represented in the AHIP survey were associated with firms with 10 or fewer employees.

<sup>1</sup> Small Group Health Insurance in 2008: A Comprehensive Survey of Premiums, Consumer Choices, and Benefits, AHIP Center for Policy and Research (March 2009).

- Among states with substantial enrollment represented in the survey, average monthly premiums ranged from a high of \$565 (\$1,483 for family coverage) in West Virginia to a low of \$302 (\$793 for family coverage) in North Dakota.
- Among employees with small group coverage, sixty-eight (68) percent had a PPO plan in 2010, with both in-network and out-of-network benefits. Twenty-three (23) percent had a health maintenance organization (HMO) coverage 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). Health reimbursement accounts (HRA) with a qualifying HDHP and indemnity plans made up the remaining two (2) percent of enrollees.
- Twenty-four (24) percent of small group enrollees in the survey had a choice of two or more benefit plans. Of workers offered an HSA plan, approximately forty (40) percent also had a choice of an alternative plan, usually a PPO or HMO/POS plan. Forty-four (44) percent of enrollees in small groups chose HSA/HDHP plans when offered a choice among these and other product types.
- PPO plans purchased by small employers had an average individual deductible of \$1,569, an average coinsurance rate of 23 percent, an average copayment of \$27 for primary care physician visits (in-network), and an average annual out-of-pocket limit of \$3,415. An average HSA/HDHP plan had an individual deductible of \$2,814 but had relatively small cost-sharing requirements above the deductible. The average annual out-of-pocket limit for HSA/HDHP plans in the small group market was approximately \$3,887. An average HMO/POS plan in the small group market had copayments of about \$24 for primary care office visits and about \$35 for specialist visits.

In general, 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 2010, 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 groups generally consist of firms with 2-50 employees, although some states allow self-employed people – so-called “groups of one” – to purchase insurance in the small group market. 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.

Small group health insurance is 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. Operating under state law, fully insured coverage is subject to state benefit mandates and premium taxes or assessments.

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 demographics of enrollees in a group, but place limits on the magnitude of adjustments for health status and claims experience.

Variation in small group premiums across and within states can be wide. Factors affecting premiums include state regulatory rules and rating requirements, health status or health risk factors among state or local residents, state premium taxes or assessments, the cost of hospital and physician services in local areas and the types of products chosen and degree of deductibles or other cost-sharing purchased by small businesses.

## PREMIUMS IN THE SMALL GROUP MARKET

Nationwide, the average premium for small group coverage in AHIP’s 2010 survey was \$426 per month for single coverage and \$1,117 per month for family coverage (see Table 1). On an annual basis, this equates to \$5,107 per year for single coverage and \$13,409 for family coverage.<sup>2</sup>

Premiums from more than 477,000 small groups are represented in the survey. Over 348,000 groups had 10 or fewer employees, with almost 1.4 million covered workers. There were over 91,000 groups in the survey with between 11 and 25 employees; these firms had

Table 1. Premiums – Small Group Market, 2010

	Annual Single	Annual Family	Monthly Single	Monthly Family
Firms with 50 or Fewer Employees	\$5,107	\$13,409	\$426	\$1,117

Source: AHIP Center for Policy and Research.

over 1.2 million covered workers. Small groups with between 26 and 50 employees were represented by about 37,000 groups in the survey, covering over 1 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 large numbers of employees had lower premiums than those with fewer

employees. For example, firms with between 26 and 50 employees paid an average of \$406 per month for single coverage and \$1,065 per month for family coverage. Firms with between 11 and 25 employees paid an average of \$419 per month for single coverage and \$1,100 per month for family coverage. Firms with 10 or fewer employees had average premiums of \$446 per month for single coverage and \$1,172 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.

*Comparison with Premiums for Larger Groups.* On average, large groups (those with more than 50 employees) appear to have premium levels similar to those of small groups. However, to help keep premiums affordable, small firms tend to offer coverage with higher deductibles.

<sup>2</sup> 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 2010 survey to create estimates for a family of four.

Table 2. Number of Groups, Covered Employees, Covered Lives, and Premiums by Group Size – Small Group Market, 2010

	Number of Groups in Survey	Total Covered Employees	Total Covered Lives	Average Monthly Premium - Single Coverage	Average Monthly Premium - Family Coverage
10 or Fewer Employees	348,676	1,399,749	1,899,882	\$446	\$1,172
11 - 25 Employees	91,726	1,264,273	1,734,609	\$419	\$1,100
26 - 50 Employees	36,668	1,048,805	1,446,547	\$406	\$1,065
All Groups	477,070	3,712,827	5,081,038	\$426	\$1,117

Source: AHIP Center for Policy and Research.

Note: Premiums calculated for groups with no more than 50 employees

The KFF survey for all firms with 3 or more employees – which is heavily weighted toward groups with more than 50 workers – reported slightly lower average premiums in 2010 than AHIP’s survey of small group plans. KFF reported average premiums of \$421 per month for single coverage, and \$1,147 per month for family coverage in 2010.<sup>3</sup> KFF reported that premiums for the smallest size-of-firm category in their survey – those with 3 to 199 employees – averaged \$420 per month for single coverage, and \$1,104 per 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 \$1,146, while the average individual deductible for small groups was \$1,569 (see Table 4). 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 3. Small Group Premiums vs. Premiums for Slightly Larger Groups, 2010

	Average Monthly Premium Single	Average Monthly Premium Family
AHIP Small Group Survey, 2010 (2-50)	\$426	\$1,117
KFF Employer Survey, 2010 (3+)	\$421	\$1,147
KFF Employer Survey, 2010 (3-199)	\$420	\$1,104

Source: AHIP Center for Policy and Research and KFF.

*Premiums by state.* Table 5 (on page 6) shows how premium rates vary by state for all small group plans. States with survey responses representing fewer than

Table 4. Average Annual Deductible for PPO Plans, Single Coverage, 2010

	AHIP 2010 (Firm Size 50 or fewer)	Kaiser 2010 (Firm Size 3-199)
Average Annual Deductible	\$1,569	\$1,146

Source: AHIP Center for Policy and Research and KFF.

<sup>3</sup> Kaiser Family Foundation, Employer Health Benefits: 2010 Annual Survey, (September 2, 2010). See: <http://ehbs.kff.org/>.

3,000 covered lives are not shown separately in Table 5 or the premium tables that follow; however, data from those states are included in the national totals. Among states with large populations, California and Virginia had lower-than-average premium rates, while Florida, Illinois, and New York had 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 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 shows average premium rates by state for firms with between 26 and 50 employees; Table 7 shows

average premiums by state for firms with 11-25 employees, and Table 8 shows average premiums for firms with 10 or fewer employees.

*Premium variation among small firms.* A subset of firms in the AHIP survey reported in a format that allows for distributional tabulations on premium variation. Nine AHIP member firms responded in this format, representing over 3 million covered workers. The distributions described below are controlled to aggregated totals from the entire survey universe of 11 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 90<sup>th</sup> percentile nationwide for groups with 10 or fewer employees (including all types of products and benefits) are over four times the premiums of the smallest groups in the 10<sup>th</sup> percentile of premiums (see Table 9). However, the rate variation nationwide is less than a 4.0:1 ratio for firms with 11-50 employees.

Table 5. Premiums by State – All Small Groups, 2010

State	Average Monthly Premium for Single Coverage	Average Monthly Premium for Family Coverage
WEST VIRGINIA	\$565	\$1,483
NEW YORK	\$554	\$1,455
NEW HAMPSHIRE	\$524	\$1,376
NEBRASKA	\$490	\$1,286
MASSACHUSETTS	\$483	\$1,270
ILLINOIS	\$447	\$1,173
FLORIDA	\$437	\$1,148
COLORADO	\$429	\$1,127
TEXAS	\$427	\$1,121
United States	\$426	\$1,117
WISCONSIN	\$424	\$1,115
CALIFORNIA	\$423	\$1,112
OKLAHOMA	\$422	\$1,107
SOUTH CAROLINA	\$421	\$1,105
MINNESOTA	\$415	\$1,091
TENNESSEE	\$410	\$1,077
NORTH CAROLINA	\$410	\$1,077
INDIANA	\$408	\$1,071
MONTANA	\$408	\$1,070
ARIZONA	\$405	\$1,063
GEORGIA	\$404	\$1,060
VIRGINIA	\$399	\$1,049
MISSISSIPPI	\$399	\$1,048
LOUISIANA	\$392	\$1,028
MISSOURI	\$387	\$1,017
OHIO	\$386	\$1,014
MAINE	\$386	\$1,013
KANSAS	\$386	\$1,013
PENNSYLVANIA	\$383	\$1,005
NEVADA	\$381	\$1,001
IOWA	\$372	\$976
ALABAMA	\$353	\$928
MICHIGAN	\$349	\$917
WASHINGTON	\$332	\$873
KENTUCKY	\$332	\$872

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UTAH	\$329	\$863
ARKANSAS	\$305	\$801
NORTH DAKOTA	\$302	\$793

Source: AHIP Center for Policy and Research.

Table 6. Premiums by State – Small Groups with 26-50 Employees, 2010

State	Average Monthly Premium for Single Coverage	Average Monthly Premium for Family Coverage
NEW YORK	\$565	\$1,485
NEW HAMPSHIRE	\$512	\$1,345
NEBRASKA	\$443	\$1,164
ILLINOIS	\$437	\$1,147
CALIFORNIA	\$428	\$1,125
COLORADO	\$418	\$1,098
MINNESOTA	\$414	\$1,087
WISCONSIN	\$414	\$1,086
United States	\$406	\$1,065
FLORIDA	\$395	\$1,037
INDIANA	\$389	\$1,021
LOUISIANA	\$386	\$1,014
GEORGIA	\$383	\$1,006
VIRGINIA	\$383	\$1,005
TEXAS	\$379	\$996
TENNESSEE	\$378	\$993
NORTH CAROLINA	\$372	\$976
MAINE	\$370	\$971
OKLAHOMA	\$369	\$969
PENNSYLVANIA	\$369	\$969
MISSISSIPPI	\$366	\$960
SOUTH CAROLINA	\$366	\$960
OHIO	\$365	\$959
MISSOURI	\$361	\$949
KANSAS	\$355	\$933
IOWA	\$354	\$929
ARIZONA	\$352	\$925
NEVADA	\$346	\$908

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KENTUCKY	\$331	\$869
WASHINGTON	\$330	\$866
UTAH	\$325	\$853
MICHIGAN	\$311	\$818
ARKANSAS	\$265	\$696

Source: AHIP Center for Policy and Research.

Table 7. Premiums by State – Small Groups with 11-25 Employees, 2010

State	Average Monthly Premium for Single Coverage	Average Monthly Premium for Family Coverage
NEW YORK	\$577	\$1,514
NEW HAMPSHIRE	\$523	\$1,374
NEBRASKA	\$449	\$1,179
MASSACHUSETTS	\$439	\$1,153
ILLINOIS	\$438	\$1,151
CALIFORNIA	\$433	\$1,136
COLORADO	\$420	\$1,102
United States	\$419	\$1,100
WISCONSIN	\$416	\$1,093
VIRGINIA	\$408	\$1,072
SOUTH CAROLINA	\$406	\$1,065
FLORIDA	\$404	\$1,060
GEORGIA	\$402	\$1,056
TEXAS	\$402	\$1,055
MINNESOTA	\$401	\$1,054
TENNESSEE	\$399	\$1,047
NORTH CAROLINA	\$399	\$1,047
INDIANA	\$398	\$1,045
OKLAHOMA	\$398	\$1,045
PENNSYLVANIA	\$391	\$1,028
MISSOURI	\$387	\$1,016
MAINE	\$385	\$1,010
OHIO	\$383	\$1,006
ARIZONA	\$380	\$999
LOUISIANA	\$371	\$975
MISSISSIPPI	\$370	\$973

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KANSAS	\$361	\$948
NEVADA	\$357	\$937
IOWA	\$347	\$912
KENTUCKY	\$333	\$874
WASHINGTON	\$327	\$859
MICHIGAN	\$327	\$858
UTAH	\$318	\$836
ARKANSAS	\$295	\$775

Source: AHIP Center for Policy and Research.

Table 8. Premiums by State – Small Groups with 10 or Fewer Employees, 2010

State	Average Monthly Premium for Single Coverage	Average Monthly Premium for Family Coverage
NEBRASKA	\$579	\$1,519
MASSACHUSETTS	\$545	\$1,430
NEW HAMPSHIRE	\$539	\$1,415
NEW YORK	\$536	\$1,408
FLORIDA	\$489	\$1,283
TEXAS	\$484	\$1,270
OKLAHOMA	\$478	\$1,255
SOUTH CAROLINA	\$474	\$1,244
ARIZONA	\$469	\$1,232
ILLINOIS	\$466	\$1,224
TENNESSEE	\$452	\$1,188
WISCONSIN	\$448	\$1,177
INDIANA	\$447	\$1,174
MISSISSIPPI	\$447	\$1,173
United States	\$446	\$1,172
NORTH CAROLINA	\$445	\$1,169
COLORADO	\$441	\$1,159
KANSAS	\$432	\$1,134
MONTANA	\$430	\$1,130
MINNESOTA	\$430	\$1,129
LOUISIANA	\$430	\$1,128
NEVADA	\$429	\$1,127
GEORGIA	\$424	\$1,113

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OHIO	\$415	\$1,089
CALIFORNIA	\$414	\$1,087
MISSOURI	\$413	\$1,084
IOWA	\$413	\$1,084
VIRGINIA	\$404	\$1,061
PENNSYLVANIA	\$397	\$1,043
MAINE	\$395	\$1,038
MICHIGAN	\$379	\$994
ARKANSAS	\$352	\$925
UTAH	\$348	\$914
WASHINGTON	\$341	\$895
KENTUCKY	\$332	\$872

Source: AHIP Center for Policy and Research.

Table 9. Premium Variation by Group Size – Small Group Market, 2010

	10 <sup>th</sup> Percentile	Mean	90 <sup>th</sup> Percentile	Ratio of 90 <sup>th</sup> Percentile to 10 <sup>th</sup> Percentile
10 or Fewer Employees	\$184	\$446	\$803	4.4:1
11 - 25 employees	\$185	\$419	\$721	3.9:1
26 - 50 employees	\$188	\$406	\$676	3.6:1
All Small Groups	\$181	\$426	\$750	4.2:1

Source: AHIP Center for Policy and Research.

## 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 almost 4 million workers.

AHIP asked survey respondents to provide separate responses for indemnity plans, PPO coverage, HSA-eligible high-deductible health plans, HMOs (including those with POS options), and health reimbursement arrangement (HRA) plans.

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 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 a POS option have extensive benefits outside of the HMO network. Moreover, some product types may be more common in certain regions of the country. In summary, 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 68 percent of the policies in-force and nearly 2.7 million covered employees (see Table 10). Twenty-three percent of workers (just over 900,000) had HMO/POS coverage; 7 percent of employees (262,000) had HSA/HDHP coverage. Roughly 51,000 employees had indemnity coverage and 32,000 had HRA coverage.

Table 10. Product Type by Covered Employees – Small Group Market, 2010

	Number of Covered Employees	Distribution of Covered Employees
PPO	2,694,242	68%
HMO/POS	904,741	23%
HSA/HDHP	262,630	7%
HRA/HDHP	31,566	1%
Indemnity	51,013	1%
Total	3,944,192	100.0%

Source: AHIP Center for Policy and Research.  
 Note: Total number of covered employees is more than noted in Table 2 due to reporting.

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, 76 percent of employees in firms with fewer than 50 workers were offered one plan; 18 percent were offered two plans; and only six percent were offered three or more benefit plans.

Table 11. Probability of a Choice of Plans or Benefit Packages - Small Group Market, 2010

Number of Plans Offered	Percentage of Small Groups (50 or fewer employees)
One plan	76%
Two plans	18%
Three or more plans	6%

Source: AHIP Center for Policy and Research.  
 Note: Micro-data response only.

However, among small groups offering HSA/HDHP coverage, approximately 40 percent offered employees additional coverage options (see Table 12). Among firms with 10 or fewer workers, 27 percent of workers offered a HSA/HDHP plan were also offered different health plans. By contrast, among firms with between 11 and 25 employees, 70 percent of employees offered HSA/HDHP coverage had alternative coverage options, and among groups with between 26 and 50 workers, 81 percent of workers offered HSA/HDHP coverage had alternative coverage options.

Table 12. Percentage of Employees with HSA/HDHP Choice as Only Option or One of Other Options by Group Size – Small Group Market, 2010

	HSA/HDHP Only Option	HSA/HDHP with Other Options
10 or Fewer Employees	73%	27%
11-25 Employees	30%	70%
26-50 Employees	19%	81%
All Small Groups	60%	40%

Source: AHIP Center for Policy and Research.

Among small group plans offering HSA/HDHP coverage as an option, a HMO/POS plan was also available nearly 36 percent of the time and a PPO plan was available about 52 percent of the time (see Table 13).

**Table 13. Other Plans Available to HSA/HDHP Enrollees with a Choice of Plans – Small Group Market, 2010**

	Percentage of Product Types Offered
HMO/POS	36%
PPO	52%
HRA	*
More than One	12%
Total	100%

Source: AHIP Center for Policy and Research.

\*Less than 1 percent.

Note: Micro-data response only.

**Table 14. Percentage of Employees with a Choice of Plan that Chose HSA/HDHP Coverage by Group Size – Small Group Market, 2010**

	Percentage that chose HSA/HDHP option
10 or Fewer Employees	49%
11-25 Employees	45%
26-50 Employees	40%
All Small Groups	44%

Source: AHIP Center for Policy and Research.

Note: Micro-data response only.

**Table 15. Comparison of Average Annual Out-of-Pocket Limits within Annual Deductible Levels by Product Type – Small Group Market, 2010**

	HSA/HDHP	PPO
\$0 (no deductible)	-	\$2,136
\$1-\$249	-	\$3,701
\$250-\$499	-	\$2,636
\$500-\$749	-	\$2,682
\$750-\$999	-	\$4,620
\$1,000-\$1,499	\$2,434	\$2,988
\$1,500-\$1,999	\$2,148	\$2,935
\$2,000+	\$4,328	\$4,333
Overall	\$3,887	\$3,415

Source: AHIP Center for Policy and Research.

Note: Breakout data from micro-data response only.

## DETAILED COST-SHARING INFORMATION

The cost-sharing features included in plans purchased by small groups are summarized in Table 16 and explored in more detail in the tables that follow. It is important to note that certain information is taken from micro-data company responses only. Also, cost-sharing information was calculated for separate policies with no more than 50 employees.

The average deductible for single coverage was approximately \$1,569 for PPO plans, \$2,814 for HSA/HDHP plans, and \$1,573 for HMO/POS plans (see Table 17). For HMO/POS and PPO plans, these averages reflect only those plans that have deductibles. See table 18 for a breakout of average deductible by product type across associated policy size by number of employees. 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.

Almost 80 percent of PPO plans in the small group market required enrollees to pay a percentage of health costs over the deductible, with coinsurance rates averaging 23 percent (see Table 19). By contrast, about 75 percent of HSA/HDHP plans and 65 percent 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 another common cost-sharing feature among network-based health insurance plans. About 99 percent of HMO/POS plans and 94 percent of PPO plans in the small group market charged copayments for primary care office visits (see Table 20).

Table 16. Benefit Characteristics by Product Type – Small Group Market, 2010

	HSA/HDHP	PPO	HMO/POS
Average Annual Deductible (Single)	\$2,814	\$1,569	\$1,573
Percent with a Deductible	100%	96%	60%
Average Annual Out-of-Pocket Maximum	\$3,887	\$3,415	\$2,756
Percent with an Out-of-Pocket Maximum	100%	95%	80%
Average Coinsurance Level	18%	23%	22%
Percent with Coinsurance	24%	79%	35%
Average Primary Care Office Visit Copayment	\$33	\$27	\$24
Percent with Primary Care Copayment	20%	94%	99%
Average Specialist Visit Copayment	\$38	\$39	\$35
Percent with Specialist Copayment	20%	91%	99%

Source: AHIP Center for Policy and Research.

Note: Breakout data from micro-data response only.

Table 17. Annual Deductible Levels by Product Type – Small Group Market, 2010

	Percent of Employees in Survey with a Deductible		
	HSA/HDHP	PPO Plans In Network	POS or HMO Plans In Network
\$1 - \$249	0%	1%	*
\$250 - \$499	0%	13%	2%
\$500 - \$749	*	20%	17%
\$750 - \$999	1%	7%	2%
\$1,000 - \$1,499	6%	18%	26%
\$1,500 - \$1,999	14%	10%	18%
\$2,000 +	79%	31%	35%
Average Purchased	\$2,814	\$1,569	\$1,573

Source: AHIP Center for Policy and Research.

\*Less than 1 percent.

Note: Breakout data from micro-data response only.

**Table 18. Deductible Levels by Product Type and Policy Size – Small Group Market, 2010**

	HSA/HDHP	POS or HMO Plans in Network	PPO Plans In Network
10 or Fewer Employees	\$2,957.91	\$1,582.65	\$1,512.42
11-25 Employees	\$2,820.21	\$1,583.88	\$1,379.81
26-50 Employees	\$2,842.14	\$1,596.84	\$1,389.53

Source: AHIP Center for Policy and Research.  
Note: Breakout data from micro-data response only.

**Table 19. Coinsurance Levels by Product Type – Small Group Market, 2010**

Percent of Employees in Survey			
	HSA/HDHP	PPO Plans In Network	POS or HMO Plans In Network
No coinsurance	76%	21%	65%
Less than 10%	0%	1%	*
10% - 19%	2%	16%	3%
20% - 29%	21%	43%	23%
30% - 39%	*	12%	9%
40% - 49%	*	7%	*
50%	1%	1%	*
Average Purchased	18%	23%	22%

Source: AHIP Center for Policy and Research.  
\*Less than 1 percent.  
Note: Breakout data from micro-data response only.

Copayments averaged approximately \$27 per visit in 2010. Likewise, most PPO and HMO/POS plans required copayments 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 \$35 for HMO/POS coverage, while copayments for primary care averaged \$24 (see Table 21).

**Table 20. Primary Care Office Visit Copayments by Product Type – Small Group Market, 2010**

	PPO Plans In Network	POS or HMO Plans In Network
Percentage of Policies with a Primary Care Co-payment	94%	99%
Percent of Employees in Survey with a Primary Care Office Visit Copayment		
Less than \$10	*	*
\$10 - \$14.99	8%	7%
\$15 - \$19.99	7%	5%
\$20 - \$24.99	32%	29%
\$25 - \$29.99	10%	21%
\$30 or more	43%	37%
Average Purchased	\$27	\$24

Source: AHIP Center for Policy and Research.  
\*Less than 1 percent.  
Note: Breakout data from micro-data response only.

**Table 21. Specialist Office Visit Copayments by Product Type – Small Group Market, 2010**

	PPO Plans In Network	POS or HMO Plans In Network
Percentage of Policies with a Specialist Co-payment	91%	99%
Percent of Employees in Survey with a Specialist Office Visit Copayment		
Less than \$10	*	*
\$10 - \$14.99	4%	6%
\$15 - \$19.99	3%	2%
\$20 - \$24.99	12%	11%
\$25 - \$29.99	5%	10%
\$30 or more	76%	71%
Average Purchased	\$39	\$35

Source: AHIP Center for Policy and Research.  
\*Less than 1 percent.  
Note: Breakout data from micro-data response only.

One measure of 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

**Table 22. Annual Out-of-Pocket Limits by Product Type – Small Group Market, 2010**

	HSA/HDHP	PPO Plans In Network	POS or HMO Plans In Network
Percentage of Policies with an Out-of-Pocket Limit	100%	95%	80%
Percent of Employees in Survey with an Out-of-Pocket Limit			
< \$500	0%	*	*
\$500 - \$999	0%	2%	6%
\$1,000 - \$1,499	4%	11%	13%
\$1,500 - \$1,999	8%	6%	18%
\$2,000 - \$2,999	27%	27%	19%
\$3,000 +	60%	54%	44%
Average Purchased	\$3,887	\$3,415	\$2,756

Source: AHIP Center for Policy and Research.  
 \*Less than 1 percent.  
 Note: Breakout data from micro-data response only.

**Table 23. Prescription Drug Copayments by Product Type – Small Group Market, 2010**

	HSA/HDHP	PPO Plans In Network	POS or HMO Plans In Network
Percentage of Policies with Generic Brand Copayment	26%	96%	99%
Average Purchased	\$11	\$11	\$12
Percentage of Policies with Preferred Brand-Name Copayment	26%	97%	97%
Average Purchased	\$33	\$32	\$30
Percentage of Policies with Non-Preferred Brand-name Copayment	26%	97%	97%
Average Purchased	\$51	\$53	\$49

Source: AHIP Center for Policy and Research.

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

In 2010, most small groups had explicit limits on consumers' annual out-of-pocket costs. HSA/HDHP plans are required by law to have limits.<sup>4</sup> See table 22 for annual out-of-pocket limits for HSA/HDHP, HMO, and PPO coverage. ACA will no longer allow for lifetime or annual benefit maximums. 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 generally intended to cover most routine medical expenses after the deductible is met – that is the purpose of the health savings account itself.

Most small group plans have 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”). For example, PPO products had an average copayment for generic drugs of \$11; an average copayment for preferred brand-name drug of \$32; and an average copayment for non-preferred brand-name drugs of \$53 (see Table 23).

## 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

<sup>4</sup> For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,950 for single coverage and \$11,900 for family coverage.

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 an HSA, whether or not an account is actually established at the time of sale.
HRA	A health reimbursement arrangement (HRA) product; any HDHP product that is designed and marketed to be used in conjunction with an HRA.
PPO	A preferred provider organization (PPO) product; network-based plans that provided 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 an HMO.
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 an HMO. Note that this category was combined with HMO plans.
IND	An indemnity product; any product that is not based on provider network. Respondents were instructed to report indemnity products designed to be sold in conjunction with an HSA as HSA/HDHP products.

policies sold to groups with 50 or fewer employees, even if their state's definitions 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 2010.

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 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 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 benefit 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 definitions listed above.

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 on 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, 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 (taking into account group size).

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 2010 Kaiser Family Foundation (KFF) employer health benefits survey. The KFF data on family premiums are for a family of four.

## 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, Dan LaVallee, Teresa Mulligan 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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