AHIP
Center for Policy and Research

Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits

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Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits

The latest in a series of AHIP surveys shows that the market for individually purchased coverage is more affordable and accessible than may be widely known.

December 2007

SUMMARY

In late 2006 and early 2007, America's Health Insurance Plans (AHIP) conducted a comprehensive survey of member companies participating in the individual health insurance market. The study, which is a follow-up to several previous AHIP surveys of the individual market,[1] shows that individually purchased major medical insurance is more affordable and accessible than may be widely known and that it offers a broad array of benefits.

According to the survey, most applications for coverage were approved, and the benefits commonly purchased by consumers provided substantial financial protection. In some states with restrictions on premium variation and underwriting — often known as "guaranteed issue" and "community-rated" states — overall premiums were significantly higher than average.

The survey was divided into three parts:

- premiums,
- underwriting, and
- benefits.

The data on premiums and benefits are mostly based on policies in force during December 2006 or January 2007. Therefore, the premium and benefit data are best described as a blend of 2006 and 2007 for comparison with other sources. The data on underwriting are for calendar year 2006. A wide variety of AHIP member companies responded to the survey, including large and small multi-state plans, single-state plans, and local or regional plans. For the premiums section, we obtained data on more than 2.9 million policies covering 4.2 million individuals. For the underwriting section, companies provided data on nearly 1.9 million individual applicants for coverage. The benefits section includes data on 2 million single policies and 800,000 family policies.

[1] See America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits,* (August 2005); Thomas F. Wildsmith, *Individual Health Insurance: Wide Choice of Benefits Available*, AAHP-HIAA (February 2004); Thomas D. Musco and Thomas F. Wildsmith, *Individual Health Insurance: Access and Affordability*, Health Insurance Association of America (October 2002); and Thomas D. Musco, *Individual Medical Expense Insurance Affordable, Serves Young and Old*, Health Insurance Association of America (July 2002).

Key findings:

- Nationwide, annual premiums averaged $2,613 for single coverage and $5,799 for family plans in the 2006-2007 period. For single policies, annual premiums ranged from $1,163 for persons under age 18 to $5,090 for persons aged 60-64. For family policies, premiums ranged from $2,325 for policies covering children under age 18 to $9,201 for families headed by persons aged 60-64.

- Premiums varied by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences. For example, average annual premiums for single policies reported in the survey ranged from $1,254 in Wisconsin to $8,537 in Massachusetts. However, approximately 95 percent of the policies surveyed were sold in states where the average annual premium was under $3,400 for single coverage or $7,200 for family coverage. (Importantly, Massachusetts has changed its system for individual insurance since these survey data were collected.)

- Individual coverage was purchased by people of all ages. Thirty-eight (38) percent of single policies were held by people aged 45-64; 37 percent were held by people between 25 and 44 years old; and 25 percent were held by people aged 24 and under. Likewise, 50 percent of family policies were purchased by families headed by people aged 45-64; 46 percent were held by families headed by persons aged 25-44; and 4 percent were held by families headed by individuals aged 24 or younger.

- Approximately 89 percent of applicants undergoing medical underwriting were offered coverage. Offer rates varied from a high of 96 percent for applicants under age 18 to 71 percent for applicants aged 60-64.

- Forty (40) percent of offers in the survey were at standard premium rates; 49 percent were offered at lower (preferred) rates; 11 percent were offered at higher-than-standard rates. Eight (8) percent of offers included "condition waivers," i.e., coverage exceptions for specified conditions.

- Standard or preferred rates were available in all age brackets. Among adults age 60 to 64 who were offered coverage, nearly three-quarters (74 percent) of offers were at standard or lower (preferred) rates.

- The most commonly purchased products were preferred provider organization (PPO) or point-of-service (POS) coverage, representing 78 percent of single policies and 66 percent of family policies in force.

- Ten (10) percent of single policies and 23 percent of family policies chosen provided coverage in conjunction with health savings accounts (HSAs). Notably, for HSA policies, the average out-of-pocket maximum paid by consumers often is not much higher than the average plan deductible. This may indicate that many HSA plans consider the deductible to be the primary form of cost-sharing, with little or no cost-sharing for claims above the deductible.

- Most of the policies chosen had annual out-of-pocket limits under $5,000, and the average lifetime maximum benefit (among plans with a maximum) was nearly $4 million.

- Consumers in the individual market were offered a wide range of benefits, including behavioral health, prescription drug, preventive, and maternity benefits. Inpatient and outpatient behavioral health and substance abuse benefits were included in approximately 85 percent of policies purchased in the survey.

AHIP member companies responding to the survey were asked to include only individual comprehensive or major medical coverage that is guaranteed renewable and meets the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definitions of "creditable coverage." We asked companies to report all such coverage marketed to individuals, whether as individual insurance policies or as certificates of coverage under association groups or other similar arrangements. The survey does not include Medigap, small-group major medical, large-group major medical, disability income, hospital indemnity, hospital-surgical only, short-term major medical, limited-benefit, or long-term care policies.

I. INTRODUCTION: WHY INDIVIDUAL HEALTH INSURANCE IS DIFFERENT

Nine out of ten non-elderly Americans with private health insurance receive it through their employer.[2] People generally understand how job-based coverage works, because it is the most common form of coverage.

Employer coverage is subsidized, and nearly all employers pay at least half of the premium. On average, employers pay 84 percent of the cost of single coverage and 72 percent of the cost of family coverage.[3] Therefore, employees have a strong incentive to sign up for employer coverage, regardless of their health or financial status. When nearly everybody in a firm signs up, premiums reflect the average cost of coverage for a large group of people — young and old, healthy and sick. Usually, all workers in a given workplace who choose the same coverage pay the same premium.

By contrast, the individual health insurance market is often unfamiliar and not as well understood. Because individual health insurance is not subsidized by employers, each consumer pays the entire cost, deciding whether the coverage justifies the premiums. As a result, consumers in this market tend to be very price sensitive.[4] Some consumers wait until they perceive they will need health services before purchasing coverage, resulting in higher premiums within insurance pools.

In most states, premiums for individual coverage are allowed to vary by age, which can help encourage younger people to purchase coverage. Likewise, most states allow insurers to medically underwrite new applications for coverage. This provides a powerful deterrent against waiting to purchase insurance until becoming ill, since the likelihood of illness increases with age.

Many states have high-risk pools, which allow people who cannot obtain individual health insurance for medical reasons to purchase coverage. However, premiums in high-risk pools are usually higher than the average for the individual market in the state.

In a few states, age-based premiums and medical underwriting for new policies are not allowed. "Guaranteed issue" rules require insurers to sell an individual health insurance policy without regard to a person's health, and "community rating" requires that all consumers pay the same or similar premiums without regard to age.

However, states with guaranteed issue and community rating rules tend to have higher than average premiums. Knowing that they could purchase coverage at any time, younger and healthier people may not do so in sufficient numbers to balance insurance pools. When this happens, premiums reflect the higher average costs of older and less healthy people, and people with low- or moderate-incomes may not be able to afford coverage.[5]

[2] Based on data from Figure 1, page 5 of Paul Fronstin, *Sources of Health Insurance Data and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, Employee Benefit Research Institute, Issue Brief Number 310, (October 2007).

[3] Gary Claxton, et al., *Employer Health Benefits: 2007 Annual Survey*. Washington, DC: Henry J. Kaiser Family Foundation and Health Research & Educational Trust, (September 2007).

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

[5] For an analysis of guaranteed issue and community rating rules in several states, see Leigh Wachenheim, FSA, MAAA and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, AHIP/Milliman (August 2007).

II. PREMIUMS

For this survey, AHIP members with individual major medical insurance plans in force were asked to submit premium information, by age and state. We collected data on more than 2.9 million policies, covering approximately 4.2 million individuals.

Premiums by Age

People in all age brackets purchased individual insurance. Thirty-eight (38) percent of single policies in the survey were held by persons aged 45-64; 37 percent were held by people between 25 and 44 years old; and 25 percent were held by people age 24 and under.

Of family policies in the survey, 50 percent were held by families headed by people aged 45-64; 46 percent were purchased by families headed by persons aged 25-44; and 4 percent were held by families headed by individuals aged 24 or younger (see Table 1).

The average annual premium in the survey for single coverage was $2,613, and for family coverage the average premium was $5,799 in 2006-2007 (see Table 2 on page 7).

For single policies, annual premiums ranged from $1,163 for a person under age 18 to $5,090 for a person aged 60-64. For family policies, annual premiums ranged from $2,325 for policies covering children under age 18 to $9,201 for families headed by persons aged 60-64. The average number of family members covered under family policies in the survey was three.

Premiums by State

Premiums varied significantly by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences.

Table 3 (on page 8) shows average premiums by state for single policies; Table 4 (on page 9) shows premiums for family policies. Carriers were instructed to assign each policy to the state on which its premium was based, rather than to the state in which it was originally issued. Data from states with fewer than 500 policies reported by survey respondents are included in the national totals but are not shown separately.

The data on premiums by state are more uncertain than the national averages reported elsewhere in this report. This is because the response level in many states was relatively small, both in terms of the number of policies in the data and in terms of the variety of companies reporting data in the state. However, the data show broad patterns that are noteworthy.

TABLE 1. INDIVIDUAL MARKET, DISTRIBUTION OF POLICYHOLDERS BY AGE, 2006-2007

	Single		Family	
	Policies in Survey	Percent	Policies in Survey	Percent
Under 18	273,972	12%	15,434	2%
18 - 24	291,441	13%	9,821	2%
25 - 34	448,915	20%	91,785	14%
35 - 44	382,147	17%	205,764	32%
45 - 54	420,997	18%	216,824	34%
55 - 64	454,859	20%	105,954	16%
All Age Groups (non-elderly)	2,272,331	100%	645,582	100%

Source: America's Health Insurance Plans.

TABLE 2. INDIVIDUAL MARKET, NATIONAL AVERAGE PREMIUMS BY AGE, 2006-2007					
	Single		Family		
	Policies in Survey	Average Annual Premium	Policies in Survey	Average Members per Family	Average Annual Premium
Under 18	273,972	$1,163	15,434	2.21	$2,325
18 - 24	291,441	$1,359	9,821	2.27	$2,850
25 - 29	263,642	$1,534	31,852	2.73	$3,540
30 - 34	185,273	$1,877	59,933	3.18	$4,309
35 - 39	188,537	$2,185	93,507	3.47	$4,889
40 - 44	193,610	$2,593	112,257	3.52	$5,383
45 - 49	206,424	$3,051	117,907	3.28	$5,876
50 - 54	214,573	$3,628	98,917	2.83	$6,751
55 - 59	216,674	$4,317	66,748	2.28	$7,881
60 - 64	238,185	$5,090	39,206	2.13	$9,201
All Age Groups (non-elderly)	2,272,331	$2,613	645,582	3.04	$5,799
Source: America's Health Insurance Plans.					

First, premiums ranged widely from state to state, from $8,537 in Massachusetts to $1,254 in Wisconsin for single coverage, and from $16,897 in Massachusetts to $3,087 in Wisconsin for family policies. (Premiums in Massachusetts were measured prior to the implementation of that state's health insurance reform program in July 2007.)

Second, as a general rule, states that combined community rating with guaranteed issue requirements had higher overall premiums in the individual market. The states with the three highest premium averages – Massachusetts, New Jersey, and New York – all require community rating and guaranteed issue. Premiums in Massachusetts were the highest in the nation and were roughly three times higher than the national average for the individual market.

However, most policies reported in the survey were sold in states where average premiums were closer to the national average. Approximately 95 percent of the single policies surveyed were sold in states where the average annual premium was under $3,400. Likewise, about 96 percent of family policies in the survey were sold in states where the average premium was under $7,200.

Importantly, Massachusetts dramatically changed its market for individual coverage after these survey results were completed. According to preliminary data from the new system reported by Massachusetts officials, average monthly premiums for single coverage in mid-2007 ranged from $225 to $450 ($2,700 to $5,400 annually) for "silver" (medium-benefit) plans in the 35-39 year age bracket. (More information about the new Massachusetts system can be found at www.mahealthconnector.org.)

TABLE 3. INDIVIDUAL MARKET, AVERAGE ANNUAL PREMIUMS BY STATE - SINGLE COVERAGE, 2006-2007	
State	Average Annual Premium
Massachusetts	$8,537
New Jersey	$5,326
New York	$4,734
Rhode Island	$4,412
Pennsylvania	$3,949
Maine	$3,686
Louisiana	$3,377
New Hampshire	$3,368
New Mexico	$3,362
Connecticut	$3,326
Nevada	$3,118
North Carolina	$3,080
South Carolina	$2,981
Florida	$2,949
South Dakota	$2,914
Montana	$2,866
Texas	$2,782
Wyoming	$2,688
National	$2,613
Arizona	$2,591
California	$2,565
West Virginia	$2,540
Colorado	$2,537
Kentucky	$2,537
Missouri	$2,518
Nebraska	$2,505
Indiana	$2,504
Illinois	$2,499
Ohio	$2,498
Mississippi	$2,489
Oklahoma	$2,435
Minnesota	$2,424
Georgia	$2,419
Kansas	$2,363
Virginia	$2,359
Delaware	$2,346
North Dakota	$2,316
Tennessee	$2,221
Maryland	$2,208
Alabama	$2,208
Iowa	$2,202
Arkansas	$2,153
Washington	$2,015
Idaho	$2,006
Michigan	$1,878
Utah	$1,574
Oregon	$1,297
Wisconsin	$1,254

Source: America's Health Insurance Plans.
Note: Results from Alaska and the District of Columbia, where the responding companies reported fewer than 500 policies in force, are included in the national totals but are not reported separately.

TABLE 4. INDIVIDUAL MARKET, AVERAGE ANNUAL PREMIUMS BY STATE - FAMILY COVERAGE, 2006-2007		
State	Average Annual Premium	Average Members per Family Policy
Massachusetts	$16,897	3.18
New York	$12,254	3.38
New Jersey	$10,398	2.90
Rhode Island	$10,062	3.13
Connecticut	$7,749	3.03
Louisiana	$7,171	2.93
North Carolina	$7,125	3.01
New Hampshire	$7,105	2.95
Maine	$6,951	2.91
South Dakota	$6,585	3.11
Pennsylvania	$6,535	3.45
California	$5,884	3.02
National	$5,799	3.04
Montana	$5,683	3.11
Nevada	$5,665	2.94
Missouri	$5,535	2.99
Kentucky	$5,517	2.96
Minnesota	$5,508	2.95
Texas	$5,501	3.08
Colorado	$5,446	2.98
Illinois	$5,438	3.18
Wyoming	$5,391	3.12
South Carolina	$5,346	3.10
Ohio	$5,303	3.07
Indiana	$5,302	3.05
West Virginia	$5,097	2.96
Maryland	$5,055	3.03
Nebraska	$5,037	3.31
Mississippi	$5,015	3.01
Kansas	$5,011	3.40
Arkansas	$4,891	3.02
Tennessee	$4,804	2.98
Virginia	$4,763	3.03
North Dakota	$4,715	3.20
Georgia	$4,668	3.08
Oregon	$4,627	3.04
Alabama	$4,601	2.86
Arizona	$4,598	3.07
Idaho	$4,501	3.35
Iowa	$4,477	3.20
Oklahoma	$4,406	3.09
Florida	$4,282	2.90
Michigan	$4,118	3.11
Utah	$3,259	3.67
Wisconsin	$3,087	3.20

Source: America's Health Insurance Plans.
Note: Results from Alaska, Delaware, District of Columbia, New Mexico and Washington, where responding companies reported fewer than 500 policies in force, are included in the national totals but are not reported separately.

III. UNDERWRITING

This component of the survey was intended to provide detailed data on the medical underwriting process.[6] The questions were designed to measure offer rates by age and to assess the types of coverage offered. We requested that carriers provide underwriting data in five-year age bands based on the age of the primary applicant.[7] We received data on 1,898,905 individual applicants for coverage.

We requested underwriting information on applications for individual major medical coverage received during calendar year 2006. Respondents were asked to exclude data from applications in states that require guaranteed issue in the individual market, because by definition, these states do not allow medical underwriting.[8]

AHIP members were asked to provide information on:

- the number of individual applicants for individual coverage received;
- the number that were not processed, withdrawn by the applicant, or denied for reasons unrelated to the health of the applicant;
- the number denied for medical reasons; and
- the number for which coverage was offered.

For those where coverage was offered, carriers were asked to specify the type of offer — that is, whether it was with premiums at the standard rate, higher than the standard rate, or lower than the standard, and whether there was a waiver of coverage for any medical conditions. The survey also asked about applications approved at smoker rates.

Key Findings

For a variety of reasons, some applications for individual health insurance never make it to the medical underwriting process. For example, the individual may obtain coverage elsewhere before the application is fully processed. Individuals also may withdraw their applications or be denied coverage for reasons having nothing to do with health status, such as living outside a health plan's service area.

Overall, approximately 18.5 percent of total applications received were either not processed, withdrawn by the applicant, or denied for non-medical reasons; the remaining 81.5 percent went through the medical underwriting process and serve as the basis for the analysis of offer rates in the survey (see Table 5).

TABLE 5. INDIVIDUAL MARKET, APPLICANTS UNDERWRITTEN, 2006
ALL COMPANIES REPORTING

	Received	Processing Not Completed	Withdrawn	Non-Medical Denials	Policies Medically Underwritten
Individual Applicants	1,898,905	121,269	191,704	38,725	1,547,207
As a Percentage of Those Received					
Individual Applicants	100.0%	6.4%	10.1%	2.0%	81.5%

Source: America's Health Insurance Plans.

[6] Underwriting is the process of evaluating an application for insurance. An insurance application is an offer, by the applicant to the insurer, to enter into an insurance contract. In states that allow medical underwriting, the insurer may evaluate an applicant's health status and then accept that offer, decline it, or make a counteroffer with different benefits, a different premium, or both.

[7] The "primary applicant" is defined as the person who purchases the health insurance policy and signs the contract for coverage.

[8] Policies that were issued on a guaranteed issue basis to HIPAA-qualified individuals in states that do not have a general guaranteed issue requirement were included. HIPAA, the Health Insurance Portability and Accountability Act of 1996, mandates that certain individuals who lose group health insurance be guaranteed access to individually purchased coverage. In some states, this requirement is met through a general guaranteed access requirement, or through a state-sponsored high-risk pool; in other states, certain carriers may serve as insurers of last resort for individuals who otherwise would not be able to obtain coverage. In other states, certain carriers operating in the individual health insurance market must guarantee issue policies to HIPAA-eligible individuals, even though they may underwrite other applicants for coverage.

TABLE 6. INDIVIDUAL MARKET, ANALYSIS OF OFFER RATES, 2006 ALL COMPANIES REPORTING			
	Medically Underwritten	Denials	Offers
Individual Applicants	1,547,207	174,256	1,372,951
As a Percentage of Those Medically Underwritten			
Individual Applicants	100.0%	11.3%	88.7%
Source: America's Health Insurance Plans.			

Of the 1,547,207 individuals in the survey whose applications were medically underwritten, 88.7 percent received offers of coverage (see Table 6).

Offer rates varied by age, ranging from 96 percent for people under age 18 to 71 percent for people aged 60 to 64 (see Table 7 on page 12). Likewise, 78 percent of applicants aged 55 to 59 were offered coverage, and 83 percent of applicants between the ages of 50 and 54 were offered coverage.

Roughly nine out of ten individuals (89 percent) were offered the coverage they had requested at standard or lower (preferred) premium rates (see Table 8 on page 13). Eleven (11) percent of applicants were offered rates that were higher than standard rates.

The type of offer made also varied by age. Individuals under age 30 were the most likely to be offered coverage at standard or lower (preferred) rates. As one would expect, the number of applicants offered higher premiums rises with age. Still, among adults age 60 to 64 who were offered coverage, nearly three-quarters (74 percent) of offers were at standard or lower (preferred) rates.

Eight (8) percent of applicants were offered coverage with "condition waivers," which stipulate exceptions from coverage for specified health conditions. However, not all individuals with condition waivers had higher premiums. Only four percent of applicants had both condition waivers and higher premiums (see Table 9 on page 14).

Not all responding companies were able to provide information on the types of offers made; therefore, the number of offers analyzed in Tables 8 and 9 is slightly less than the total number of offers reported in Tables 6 and 7.

We also asked companies to provide information on the number of offers made at "smoker rates." Companies reporting this information had higher-than-standard premiums for people who smoked, to reflect the higher costs of treating health problems associated with smoking. Among the responding companies providing data on this topic, approximately 12 percent of applicants offered coverage were charged smoker rates (see Table 10 on page 15).

TABLE 7. INDIVIDUAL MARKET, ANALYSIS OF OFFER RATES, BY AGE, 2006 COMPANIES REPORTING RESULTS BY AGE INDIVIDUAL APPLICANTS			
OFFER RATES (NUMBER OF APPLICANTS)			
Age of Individual Applicant	Medically Underwritten	Denials	Offered
Under 18	283,372	11,217	272,154
18 - 24	226,729	21,092	205,637
25 - 29	179,490	19,080	160,409
30 - 34	151,443	14,667	136,777
35 - 39	155,910	15,550	140,360
40 - 44	150,264	17,018	133,246
45 - 49	136,354	18,263	118,091
50 - 54	111,214	19,337	91,877
55 - 59	89,218	19,864	69,354
60 - 64	63,214	18,169	45,045
All Age Groups (non-elderly)	1,547,208	174,257	1,372,950
OFFER RATES (PERCENT OF APPLICANTS)			
Age of Individual Applicant	Medically Underwritten	Denials	Offered
Under 18	100.0%	4.0%	96.0%
18 - 24	100.0%	9.3%	90.7%
25 - 29	100.0%	10.6%	89.4%
30 - 34	100.0%	9.7%	90.3%
35 - 39	100.0%	10.0%	90.0%
40 - 44	100.0%	11.3%	88.7%
45 - 49	100.0%	13.4%	86.6%
50 - 54	100.0%	17.4%	82.6%
55 - 59	100.0%	22.3%	77.7%
60 - 64	100.0%	28.7%	71.3%
All Age Groups (non-elderly)		11.3%	88.7%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

TABLE 8. INDIVIDUAL MARKET, ANALYSIS OF OFFERS, BY TYPE AND AGE, 2006
COMPANIES REPORTING RESULTS BY AGE
INDIVIDUAL APPLICANTS

TYPE OF OFFER (NUMBER OF APPLICANTS)

Age of Individual Applicant	Standard Premium	Higher Premium	Lower (Preferred) Premium	Number of Policies Offered
Under 18	128,483	24,263	117,372	270,119
18 - 24	63,258	14,677	101,620	179,554
25 - 29	42,498	10,995	79,184	132,678
30 - 34	36,901	10,266	58,468	105,635
35 - 39	38,256	11,508	52,872	102,636
40 - 44	39,176	11,471	44,564	95,211
45 - 49	37,169	11,939	37,229	86,338
50 - 54	30,349	11,730	28,174	70,254
55 - 59	23,436	11,220	19,687	54,342
60 - 64	16,103	9,516	11,621	37,240
All Age Groups (non-elderly)	455,629	127,585	550,791	1,134,007

TYPE OF OFFER (PERCENT OF APPLICANTS)

Age of Individual Applicant	Standard Premium	Higher Premium	Lower (Preferred) Premium	Percentage of Policies Offered
Under 18	47.6%	9.0%	43.5%	100.0%
18 - 24	35.2%	8.2%	56.6%	100.0%
25 - 29	32.0%	8.3%	59.7%	100.0%
30 - 34	34.9%	9.7%	55.3%	100.0%
35 - 39	37.3%	11.2%	51.5%	100.0%
40 - 44	41.1%	12.0%	46.8%	100.0%
45 - 49	43.1%	13.8%	43.1%	100.0%
50 - 54	43.2%	16.7%	40.1%	100.0%
55 - 59	43.1%	20.6%	36.2%	100.0%
60 - 64	43.2%	25.6%	31.2%	100.0%
All Age Groups (non-elderly)	40.2%	11.3%	48.6%	100.0%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

TABLE 9. INDIVIDUAL MARKET, ANALYSIS OF CONDITION WAIVERS OFFERED, BY AGE, 2006 COMPANIES REPORTING RESULTS BY AGE INDIVIDUAL APPLICANTS			
WAIVERS (NUMBER OF APPLICANTS)			
Age of Individual Applicant	Number of Policies Offered	Condition Waiver	Higher Premium and Condition Waiver
Under 18	270,119	23,680	17,253
18 - 24	179,554	10,486	5,207
25 - 29	132,678	7,303	3,261
30 - 34	105,635	6,792	3,239
35 - 39	102,636	7,301	3,505
40 - 44	95,211	6,736	3,276
45 - 49	86,338	6,655	3,222
50 - 54	70,254	6,178	3,120
55 - 59	54,342	5,554	2,982
60 - 64	37,240	4,066	2,452
All Age Groups (non-elderly)	1,134,007	84,751	47,517
WAIVERS (PERCENT OF APPLICANTS)			
Age of Individual Applicant	Policies Offered	Condition Waiver	Higher Premium and Condition Waiver
Under 18	100.0%	8.8%	6.4%
18 - 24	100.0%	5.8%	2.9%
25 - 29	100.0%	5.5%	2.5%
30 - 34	100.0%	6.4%	3.1%
35 - 39	100.0%	7.1%	3.4%
40 - 44	100.0%	7.1%	3.4%
45 - 49	100.0%	7.7%	3.7%
50 - 54	100.0%	8.8%	4.4%
55 - 59	100.0%	10.2%	5.5%
60 - 64	100.0%	10.9%	6.6%
Weighted Average		7.5%	4.2%
Source: America's Health Insurance Plans.			

TABLE 10. INDIVIDUAL MARKET, ANALYSIS OF SMOKER RATES OFFERED, BY AGE, 2006 COMPANIES REPORTING RESULTS BY AGE INDIVIDUAL APPLICANTS			
Age of Individual Applicant	Number of Policies Offered	Smoker Rate (Number of Applicants)	Smoker Rate (Percent of Applicants)
18 - 24	126,798	12,043	9.5%
25 - 29	87,148	10,728	12.3%
30 - 34	74,435	9,147	12.3%
35 - 39	75,418	9,463	12.5%
40 - 44	71,468	10,085	14.1%
45 - 49	66,886	10,074	15.1%
50 - 54	55,053	7,388	13.4%
55 - 59	44,035	5,171	11.7%
60 - 64	30,467	3,504	11.5%
Weighted Average			12.3%
All Age Groups (non-elderly)	631,708	77,603	
Source: America's Health Insurance Plans.			

We asked companies to describe the means by which applications for individual major medical coverage were submitted, i.e., whether they were submitted by insurance agents or directly by the applicants. We also asked whether applications were submitted using an electronic process or on paper. Overall, nearly two-thirds of applications were submitted by agents, and approximately 50 percent were completed electronically via a computerized system (see Table 11).

TABLE 11. INDIVIDUAL MARKET, RECEIPT OF APPLICATIONS FOR COVERAGE, 2006						
	Total	On Paper from Agent	On Paper from Applicant	Electronically from Agent	Electronically from Applicant	Other
Total Applications	1,773,156	634,158	64,814	533,319	366,409	174,456
As a Percentage of Those Received						
Total Applications	100.0%	35.8%	3.7%	30.1%	20.7%	9.8%
Source: America's Health Insurance Plans. Note: Percentages may not sum to 100.0% due to rounding.						

IV. BENEFITS

This component of the survey was intended to provide detailed data on the benefits chosen by consumers in the individual health insurance market.

Survey participants were asked to include data on major medical policies or certificates in force during a one-month period (the most recent for which data were available), which in most cases was December 2006 or January 2007. As with the premium and underwriting data, benefit data were limited to guaranteed renewable plans that met the HIPAA definition of creditable coverage. Respondents were asked to provide separate responses for PPO coverage or HMOs that have point-of-service (POS) options; closed-network HMO plans or exclusive provider organization (EPO) plans; HSA or Archer medical savings account (MSA) plans; and indemnity plans.[9]

For network-based health plans, we have not attempted to analyze benefit differentials between in-network and out-of-network services. In general, companies were asked to report deductibles and other cost-sharing requirements based on use of in-network health care providers.

AHIP member companies responding to the portion of the survey on benefits provided data on nearly 2 million single policies and over 840,000 family policies in force. Because family policies in the survey covered an average of three individuals, this represents over 4.5 million covered lives. The most commonly purchased product among the survey responses was PPO/POS coverage, which represented 78 percent of single policies and 66 percent of family policies in force among the responding companies (see Table 12).

TABLE 12. INDIVIDUAL MARKET, POLICIES IN FORCE DURING STUDY PERIOD, 2006-2007

	Number of Policies in Survey			
Product Type	Single		Family	
PPO / POS	1,553,021	77.9%	552,703	65.7%
HSA / MSA	203,868	10.2%	195,568	23.3%
HMO / EPO	118,915	6.0%	46,274	5.5%
Indemnity	118,848	6.0%	46,184	5.5%
All Products	1,994,652	100.0%	840,729	100.0%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

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

Key Findings

Individual policies purchased from the responding companies had a wide variety of deductible levels (see Table 13 and Table 14). The average deductible for single PPO/POS plans purchased was approximately $1,700. Among the single PPO/POS plans purchased, nearly one-third had deductibles under $1,000; just over one-third had deductibles in the $1,000-$2,499 range; and nearly one-third had deductibles of $2,500 or more.

The average deductible for single HSA/MSA products purchased was approximately $2,900 for single plans and $5,300 for family plans. For HSAs, the minimum deductible required by law for 2007 is $1,050 for single policies and $2,100 for families. By law, HSA plans have a unified family deductible — there are no separate deductibles for family members.

Almost all single HMO/EPO plans purchased had either no deductible or a deductible in the $1,500 to $2,499 range.

Except for HSA/MSA plans, the survey asked for the per-person deductible under family policies. However, the fact that average per-person deductibles for family coverage are considerably higher than the corresponding average single deductibles reported by PPO/POS and HMO/EPO plans may indicate that responding companies are switching some coverage to unified family deductibles (with no per-person deductibles), and thus reported unified family deductibles instead.

TABLE 13. INDIVIDUAL MARKET, DEDUCTIBLE LEVELS, 2006-2007
PPO / POS AND HSA / MSA

	Percent of Policies in Survey			
	PPO / POS		HSA / MSA	
Deductible	Single	Family	Single	Family
$0 (none)	5.6%	0.0%	0.0%	0.0%
$1 - $499	1.6%	5.6%	0.0%	0.0%
$500 - $999	25.4%	8.1%	0.0%	0.0%
$1,000 - $1,499	16.6%	9.9%	5.8%	0.0%
$1,500 - $1,999	7.4%	17.7%	11.2%	0.0%
$2,000 - $2,499	12.6%	14.9%	22.0%	2.7%
$2,500 - $2,999	16.6%	19.9%	28.5%	2.2%
$3,000 - $3,999	3.4%	2.7%	11.9%	18.4%
$4,000 - $4,999	0.5%	14.1%	7.3%	13.3%
$5,000 - $5,999	9.8%	5.9%	13.4%	45.0%
$6,000 +	0.5%	1.1%	0.0%	18.5%
Weighted Average	$1,747	$2,753	$2,905	$5,329

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

TABLE 14. INDIVIDUAL MARKET, DEDUCTIBLE LEVELS, 2006-2007 HMO / EPO AND INDEMNITY				
	Percent of Policies in Survey			
	HMO / EPO		Indemnity	
Deductible	Single	Family	Single	Family
$0 (none)	57.5%	30.0%	0.0%	0.0%
$1 - $499	0.0%	0.0%	3.2%	2.0%
$500 - $999	1.7%	0.0%	15.1%	11.3%
$1,000 - $1,499	0.0%	0.0%	21.5%	16.1%
$1,500 - $1,999	15.5%	25.4%	13.9%	16.5%
$2,000 - $2,499	23.8%	1.3%	12.7%	21.0%
$2,500 - $2,999	1.3%	0.0%	9.0%	0.8%
$3,000 - $3,999	0.2%	41.1%	2.9%	5.1%
$4,000 - $4,999	0.0%	1.1%	0.4%	2.2%
$5,000 - $5,999	0.0%	0.0%	9.7%	9.4%
$6,000 +	0.0%	1.2%	11.6%	15.5%
Weighted Average	$615	$1,234	$2,369	$2,741

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

One measure of the financial protection provided by an insurance policy is the limit placed on the consumer's annual out-of-pocket spending. Out-of-pocket limits set a maximum amount that consumers must pay in a calendar year as a result of cost-sharing provisions (e.g., deductibles, coinsurance, co-payments).

As with deductibles, the policies sold by companies participating in the survey had a wide range of out-of-pocket limits. Average out-of-pocket limits for single policies purchased ranged from approximately $2,400 for HMO coverage to $6,100 for indemnity coverage. Behind these averages is a broad distribution of consumer choices (see Table 15 on page 19).

For HMO/EPO plans, virtually all of the single policies purchased had out-of-pocket limits in the range of $1,500 to $4,000, and the majority of family policies had out-of-pocket limits between $3,000 and $7,500.

For PPO/POS plans, out-of-pocket limits for both single and family policies chosen generally ranged from $3,000 to $7,500.

For HSA/MSA plans, nearly half of the single policies chosen had out-of-pocket limits between $2,500 and $4,000.

TABLE 15. INDIVIDUAL MARKET, ANNUAL OUT-OF-POCKET LIMITS, 2006-2007				
	Percent of Policies in Survey			
	PPO / POS		HSA / MSA	
	Single	Family	Single	Family
Percentage Without an Out-of-Pocket Limit	0.8%	0.1%	0.0%	0.0%
Distribution of Policies with a Limit				
Under $1,000	0.0%	0.0%	0.0%	0.0%
$1,000 - $1,499	0.6%	0.7%	3.4%	0.0%
$1,500 - $1,999	3.7%	4.5%	7.0%	0.0%
$2,000 - $2,499	13.5%	9.9%	7.8%	1.7%
$2,500 - $2,999	6.2%	11.5%	22.9%	1.9%
$3,000 - $3,999	25.2%	13.2%	26.1%	18.3%
$4,000 - $4,999	15.9%	16.7%	8.7%	12.8%
$5,000 - $7,499	32.2%	36.8%	24.1%	43.6%
$7,500 - $9,999	1.9%	4.9%	0.0%	4.2%
$10,000 +	0.7%	1.7%	0.0%	17.6%
Weighted Average	$4,054	$4,410	$3,483	$6,020
	Percent of Policies in Survey			
	HMO / EPO		Indemnity	
	Single	Family	Single	Family
Percentage Without an Out-of-Pocket Limit	14.0%	5.1%	0.0%	0.0%
Distribution of Policies with a Limit				
Under $1,000	0.0%	0.0%	2.0%	1.9%
$1,000 - $1,499	0.0%	0.0%	7.8%	8.0%
$1,500 - $1,999	35.4%	0.0%	14.8%	16.5%
$2,000 - $2,499	12.7%	22.3%	13.6%	16.0%
$2,500 - $2,999	0.0%	0.6%	18.2%	18.6%
$3,000 - $3,999	49.5%	19.0%	12.8%	7.4%
$4,000 - $4,999	1.0%	30.8%	6.7%	1.7%
$5,000 - $7,499	1.4%	27.3%	11.3%	12.9%
$7,500 - $9,999	0.0%	0.0%	9.7%	14.5%
$10,000 +	0.0%	0.0%	3.1%	2.5%
Weighted Average	$2,383	$4,388	$6,137	$7,664

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Another important measure of the level of financial protection provided by a policy is the lifetime maximum benefit. Among plans with a limit, the average lifetime maximums among the policies purchased ranged from approximately $3 million for HMO/EPO coverage to about $4 million for PPO/POS coverage (see Table 16). In the case of HMO/EPO plans, the majority (82 percent) of single policies sold had unlimited maximum benefits — as did approximately 43 percent of HMO/EPO family policies and 8 percent of PPO/POS policies.

TABLE 16. INDIVIDUAL MARKET, LIFETIME MAXIMUM BENEFITS, 2006-2007

	Percent of Policies in Survey			
	PPO / POS		HSA / MSA	
	Single	Family	Single	Family
Unlimited	8.3%	8.1%	3.1%	1.6%
Among Policies with a Limit				
Under $2,000,000	0.9%	0.3%	1.5%	4.0%
$2,000,000 - $2,999,999	24.3%	31.1%	10.7%	9.5%
$3,000,000 - $3,999,999	7.8%	11.5%	30.7%	36.2%
$4,000,000 - $4,999,999	0.0%	0.0%	0.0%	0.0%
$5,000,000 - $5,999,999	54.8%	43.8%	23.6%	27.1%
$6,000,000 - $7,999,999	10.8%	10.7%	25.2%	11.8%
$8,000,000 +	1.3%	2.5%	8.3%	11.3%
Weighted Average	$4,228,173	$3,985,737	$4,506,095	$4,286,300
	Percent of Policies in Survey			
	HMO / EPO		Indemnity	
	Single	Family	Single	Family
Unlimited	81.6%	43.3%	0.2%	1.5%
Among Policies with a Limit				
Under $2,000,000	0.0%	0.0%	25.6%	8.4%
$2,000,000 - $2,999,999	64.5%	63.6%	5.1%	6.0%
$3,000,000 - $3,999,999	0.0%	0.0%	11..5%	17.0%
$4,000,000 - $4,999,999	0.0%	0.0%	0.0%	0.0%
$5,000,000 - $5,999,999	35.5%	36.4%	55.2%	64.9%
$6,000,000 - $7,999,999	0.0%	0.0%	2.7%	3.7%
$8,000,000 +	0.0%	0.0%	0.0%	0.0%
Weighted Average	$3,066,080	$3,092,945	$3,689,237	$4,179,936

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Table 17 shows coinsurance levels, which commonly ranged from 20 to 29 percent among PPO/POS plans with coinsurance requirements. Most HSA/MSA plans in the survey did not have coinsurance obligations. Where applicable, we asked companies to report coinsurance levels for in-network benefits only. Among plans with primary care co-payments, average co-payment levels were roughly $20 for HMO/EPO plans and $30 for PPO/POS plans (see Table 18).

TABLE 17. INDIVIDUAL MARKET, COINSURANCE LEVELS, 2006-2007				
	Percent of Policies in Survey			
	PPO / POS		HMO / EPO	
Coinsurance Level	Single	Family	Single	Family
No Coinsurance	17.6%	14.7%	64.5%	76.3%
Less than 10%	0.0%	0.0%	0.0%	0.0%
10% - 19%	2.0%	1.4%	1.9%	0.7%
20% - 29%	45.7%	47.9%	15.6%	14.1%
30% - 39%	18.4%	26.1%	15.8%	6.6%
40% - 49%	12.0%	0.2%	0.0%	0.0%
50% or more	4.3%	9.7%	2.1%	2.2%
Weighted Average	23.5%	25.9%	25.8%	25.4%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

TABLE 18. INDIVIDUAL MARKET, PRIMARY CARE OFFICE VISIT CO-PAYMENTS, 2006-2007				
	Percent of Policies in Survey			
	PPO / POS		HMO / EPO	
	Single	Family	Single	Family
Percentage without primary care co-payments ($0)	5.9%	12.1%	0.0%	0.0%
Co-payment				
Less than $10	1.5%	3.9%	0.0%	0.0%
$10 - $14.99	0.9%	0.6%	7.8%	6.8%
$15 - $19.99	8.2%	9.8%	18.3%	23.3%
$20 - $24.99	22.6%	1.8%	23.7%	27.3%
$25 - $29.99	22.4%	30.4%	23.5%	28.3%
$30 - $39.99	18.3%	28.8%	26.0%	13.8%
$40 - $49.99	26.1%	24.8%	0.6%	0.4%
$50 or more	0.0%	0.0%	0.1%	0.1%
Weighted Average	$28	$29	$22	$21

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

Among PPO/POS plans in the survey, average co-payments for specialist visits were $7 to $8 higher than average co-payments for primary care visits. Among HMO/EPO plans purchased, average co-payments for specialist visits were $3 to $5 higher than average co-payments for primary care visits (see Table 19). About three-quarters of the PPO/POS plans selected had specialist co-payments in the range of $30 to $50. Among HMO/EPO plans chosen, co-payments for specialist visits most commonly ranged from $30 to $40.

TABLE 19. INDIVIDUAL MARKET, SPECIALIST VISIT CO-PAYMENTS, 2006-2007

	Percent of Policies in Survey			
	PPO / POS		HMO / EPO	
	Single	Family	Single	Family
Co-payment				
Less than $10	0.2%	0.1%	0.0%	0.0%
$10 - $14.99	2.3%	1.2%	7.6%	6.7%
$15 - $19.99	2.1%	0.7%	7.6%	22.8%
$20 - $24.99	6.8%	1.2%	6.8%	8.8%
$25 - $29.99	8.3%	8.6%	17.7%	19.9%
$30 - $39.99	37.0%	31.0%	59.7%	41.5%
$40 - $49.99	35.6%	44.6%	0.0%	0.0%
$50 or more	7.7%	12.6%	0.6%	0.3%
Weighted Average	$35	$37	$27	$24

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

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 other medical expenses; or through a separate "drug card" benefit subject to its own deductibles and co-payments. Every carrier participating in the survey reported offering drug coverage through one of these two methods, and some carriers offered both types of drug coverage.

The vast majority of individual market policyholders in the survey had drug benefits. Most PPO/POS and HMO/EPO policies used drug cards, and most drug coverage in HSA/MSA and indemnity plans was integrated with other medical expenses (see Table 20 on page 23).

When prescription drug coverage is provided as a separate drug card benefit, it is common to provide different levels of cost sharing for different categories of drugs, such as generic drugs, brand-name drugs on a preferred list, and non-preferred brand-name drugs. These different levels of coverage are called "tiers" and are intended to encourage use of generic or preferred drugs when appropriate. Most separate benefits for PPO/POS and HMO/EPO plans provided more than one tier of coverage; none of the participating carriers reported using more than four tiers (see Table 21 on page 23).

TABLE 20. INDIVIDUAL MARKET, DRUG COVERAGE OFFERED AND PURCHASED, 2006-2007				
	Percent of Companies Offering Types of Drug Coverage			
	PPO / POS		HSA / MSA	
	Single	Family	Single	Family
"Integrated" Drug Benefit	47.6%	42.0%	100.0%	100.0%
Separate Drug Card	90.5%	89.3%	53.9%	42.0%
	Percent Purchasing Drug Coverage			
"Integrated" Drug Benefit	36.4%	23.0%	96.6%	97.0%
Separate Drug Card	59.9%	69.7%	1.2%	1.9%
Total	96.3%	92.7%	97.8%	98.9%
	Percent of Companies Offering Types of Drug Coverage			
	HMO / EPO		Indemnity	
	Single	Family	Single	Family
"Integrated" Drug Benefit	59.0%	52.4%	94.7%	94.8%
Separate Drug Card	90.6%	63.6%	24.0%	32.0%
	Percent Purchasing Drug Coverage			
"Integrated" Drug Benefit	52.1%	50.1%	44.6%	36.2%
Separate Drug Card	47.9%	49.2%	3.2%	3.0%
Total	100.0%	99.3%	47.8%	39.2%

Source: America's Health Insurance Plans.
Note: Several responding companies offered policies with integrated drug benefits and policies with separate drug card benefits.

TABLE 21. INDIVIDUAL MARKET, SEPARATE DRUG CARD BENEFITS, 2006-2007 TIERS OF COVERAGE				
	PPO / POS		HMO / EPO	
	Single	Family	Single	Family
1 Tier	7.1%	5.2%	8.4%	5.0%
2 Tiers	11.3%	26.7%	71.4%	70.6%
3 Tiers	52.8%	45.8%	20.2%	24.3%
4 or More Tiers	28.8%	22.3%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

Source: America's Health Insurance Plans.
Note: Percentages may not sum to 100.0% due to rounding.

The survey also asked companies whether their individual market products covered a variety of specific benefits. The results, shown in Tables 22 and 23, are weighted by the number of policies in force during the study period. The values reported are for in-network benefits only. Furthermore, these results represent the percent of policies chosen by covered individuals in the surveyed companies; they do not necessarily reflect the benefits available in the market as a whole. In some cases, such as dental, vision, and maternity benefits, coverage in the individual market often is offered as an optional rider to a standard policy. Because these riders add to premium costs, individuals make decisions — based on their own situations and likelihood of using certain services — about whether to include these benefits in their policies.

TABLE 22. INDIVIDUAL MARKET, SPECIFIC BENEFITS PURCHASED, 2006-2007
PPO / POS AND HSA / MSA

	Percent of Policies in Survey			
	PPO / POS		HSA / MSA	
	Single	Family	Single	Family
Coverage Included in Policies Purchased				
Adult Physicals	66.2%	67.1%	73.2%	74.8%
Allergy	71.9%	73.7%	84.5%	90.4%
Annual OB/GYN Visit	95.8%	94.1%	87.0%	82.1%
Bariatric Surgery	35.8%	35.0%	23.0%	15.9%
Cancer Screenings	94.1%	93.9%	90.0%	81.4%
Complementary & Alternative Therapy (Chiropractic, Naturopathy, Acupuncture, etc.)	70.0%	71.1%	75.3%	61.3%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Dental	14.0%	8.5%	6.2%	4.0%
Fertility Treatment	26.7%	26.7%	5.1%	3.2%
Inpatient Behavioral Health	93.8%	79.1%	89.5%	89.4%
Outpatient Behavioral Health	94.3%	84.3%	86.8%	83.3%
Normal Delivery	57.7%	59.5%	51.6%	40.3%
Oral Contraceptives	78.8%	76.6%	53.5%	46.8%
Inpatient Substance Abuse	85.0%	80.2%	86.2%	87.4%
Outpatient Substance Abuse	84.1%	78.5%	82.5%	80.8%
Vision	7.6%	17.8%	7.0%	4.2%
Well-Baby Care	88.0%	86.8%	80.2%	74.0%
Well-Child Visits	89.7%	88.5%	85.8%	79.4%

Source: America's Health Insurance Plans.

Some level of behavioral health coverage is included in nine out of ten policies purchased. Substance abuse coverage is only slightly less common. Coverage for complementary and alternative therapy appears to be quite popular with consumers. Vision and dental coverage were options that were chosen much less frequently.

TABLE 23. INDIVIDUAL MARKET, SPECIFIC BENEFITS PURCHASED, 2006-2007
HMO / EPO AND INDEMNITY

	Percent of Policies in Survey			
	HMO / EPO		Indemnity	
	Single	Family	Single	Family
Coverage Included in Policies Purchased				
Adult Physicals	99.5%	100.0%	79.5%	92.3%
Allergy	100.0%	100.0%	98.3%	97.1%
Annual OB/GYN Visit	99.4%	100.0%	79.6%	92.3%
Bariatric Surgery	40.9%	40.5%	21.5%	20.3%
Cancer Screenings	99.4%	100.0%	58.6%	81.8%
Complementary & Alternative Therapy (Chiropractic, Naturopathy, Acupuncture, etc.)	92.9%	96.4%	83.7%	77.7%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Dental	5.9%	2.7%	11.4%	17.5%
Fertility Treatment	15.0%	27.4%	12.3%	17.8%
Inpatient Behavioral Health	97.4%	98.0%	84.3%	98.9%
Outpatient Behavioral Health	97.4%	98.0%	83.4%	97.5%
Normal Delivery	66.5%	94.0%	87.9%	87.5%
Oral Contraceptives	39.1%	58.5%	75.7%	87.8%
Inpatient Substance Abuse	97.4%	98.1%	84.2%	93.2%
Outpatient Substance Abuse	97.3%	98.0%	83.3%	97.4%
Vision	24.8%	63.7%	11.6%	17.6%
Well-Baby Care	96.8%	97.6%	78.4%	91.1%
Well-Child Visits	100.0%	100.0%	58.5%	81.9%

Source: America's Health Insurance Plans.

V. ACKNOWLEDGEMENTS

This report – which updates AHIP's 2005 publication titled *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* – provides the largest data set on the individual health insurance market yet published. We thank the staff of AHIP member companies for taking the time to respond to our survey. AHIP policy analysts Karen Heath and Hannah Yoo were responsible for the survey design and data analysis. For more information, please contact Jeff Lemieux, Senior Vice-President for AHIP's Center for Policy and Research, at (202)778-3200 or visit www.ahipresearch.org.

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