BlueCross BlueShield Association

Pre-Deductible Coverage in the Individual Market: Better Access, More Affordable Care

RESEARCH BRIEF

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Author: Olivia Hoppe
Sr. Policy Research Analyst
Blue Cross Blue Shield Association

SUMMARY

Since passage of the Affordable Care Act (ACA), insurers have expanded the availability of pre-deductible coverage—health care services that are covered by the health insurance policy before the deductible is met. In fact, qualified health plans (QHPs) have been offering pre-deductible coverage for primary care visits at an increasing rate. As a result, plan benefit designs deliver greater upfront value to consumers. Although individual market plans have higher average deductibles than the group market, more than 80% of plans sold on the individual market provide pre-deductible coverage for common health care services, such as visits to a primary care physician. Aside from the financial benefits, offering this pre-deductible coverage encourages consumers to develop a relationship with a primary care physician, a key component of positive health outcomes. This research brief looks at the first-dollar coverage of QHPs sold on the individual-market to assess how plans cater to a diverse population of consumers and how deductibles—and services provided before the deductible—have evolved in the individual market over time. In addition, enrollees eligible for cost-sharing reductions (CSRs) —more than half of individual market enrollees—have access to plans with lower average deductibles as low as $59 in 2022.

BACKGROUND

Deductibles are a key element of the benefit design for many health insurance plans in the individual and employer group markets. In plans with a deductible, a plan member must pay out-of-pocket for covered medical services that are subject to the deductible until their expenses reach a certain level—the deductible—and then the health plan begins to pay for subsequent medical expenses and other forms of cost-sharing take effect, such as copayments and coinsurance. But some medical expenses may be covered—with or without cost-sharing —by the plan without the member having to first make payments up to the amount of the deductible for covered services. As the individual market matures, more and more QHPs available through the exchange cover certain common health care expenses, such as visits to a primary care physician, before the deductible is exhausted.

Table 1: Example of an Explanation of Benefits

SERVICE		HEALTH COVERAGE BENEFITS APPLIED			PATIENT RESPONSIBILITY		
SERVICE	AMOUNT BILLED BY PROVIDER	DISCOUNTS AND REDUCTION	AMOUNT COVERED (ALLOWED)	HEALTH PLAN RESPONSIBILITY	DEDUCTIBLE AMOUNT	COPAY PAID BY PATIENT	TOTAL PATIENT COST
ADULT OFFICE VISIT	**$150**	**$50**	**$100**	**$80**	**$0**	**$20**	**$20**

NOTE: Providers agree by contract for all allowed amounts paid by insurance carriers. The example is of an explanation of benefits—for a patient who has met their deductible—for an office visit for an adult primary care physician visit (CPT code 99214) that typically costs between $130 and $180 before insurance coverage is factored. In most cases, providers should not bill the patient for any excess charges above the contractually agreed allowed amount.

Table 1 shows an example of a health plan that provides primary care office visits before the deductible. In this health plan, an enrollee can visit their primary care physician, which typically costs around $150, and be subject only to a $20 copay. In a plan that does not provide pre-deductible coverage, this enrollee would be subject to the entire $100 allowed amount—the most an insurer will pay a provider for a particular service—until they meet their deductible amount for in-network health care services.

Consumers may have difficulty understanding the costs of health insurance, both premiums and cost-sharing. Consumers—especially those with a history of being uninsured—may face challenges picking a health insurance plan that provides the greatest value for their personal needs. Seeing a high deductible without the understanding of the services it applies to may deter consumers from plans that may actually provide a sufficient amount of pre-deductible coverage at a monthly premium that fits their financial and health care needs.

The ACA specifies the actuarial value (AV) requirements that health insurance plans must comply with as they design their benefits. AV measures the percentage of the allowed cost of covered services that the plan pays on the enrollee's behalf based on a standard population. The ACA's AV requirements guide insurers as they set deductibles and determine how much pre-deductible coverage the enrollee would receive under the policy's benefits. For example, QHPs with lower AVs, like bronze plans, typically have less pre-deductible coverage than plans with higher AVs, like gold and silver plans. At the same time, before considering tax subsidies, plans with lower AVs have lower premiums than those plans with higher AVs.[1]

After the subsidy is applied, the net premium the consumer pays may be very low or free in many cases. Under the ACA, health insurers also have to meet the following regulatory requirements when selling QHPs on the individual market:

- All health plans must cover preventive care in full without cost-sharing of any kind, even if the plan includes a deductible. The preventive care requirements under the ACA are determined by the U.S. Preventive Services Task Force and include high-value preventive services such as tests and screenings for certain chronic and terminal conditions like diabetes, heart disease and cancers.[2]
- Catastrophic plans must cover three primary care office visits per year pre-deductible, but the deductible must apply to all services other than preventive care and the three primary care visits. The deductible and maximum out-of-pocket (MOOP) for these plans are required to be set at the annual limit on out-of-pocket costs as specified under the ACA.
- High-Deductible Health Plans (HDHP) using a tax-preferred Health Savings Account (HSA) cannot cover anything pre-deductible except preventive care.[3]

To provide consumers with the most valuable health plan while keeping monthly premiums as affordable as possible, health insurers design a variety of benefit packages that maximize usefulness to as many consumers as possible while meeting AV requirements under the law. This brief looks at the first-dollar coverage of QHPs sold on the individual market to assess how plans cater to a diverse population of consumers and how deductibles—and services provided before the deductible—have evolved in the individual market over time.

1 One notable example is that silver plans offered on the exchange, even though the stated AV may be only 70%, often have higher premiums than gold plans because the cost of providing cost-sharing reductions, which increase the AV of a silver plan based on the income of the enrollee, is typically loaded into the silver premium.

2. https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html

3. No catastrophic plan can qualify as a "high-deductible health plan" because of the three primary care visit requirement and the requirement that the deductible be equivalent to the maximum out-of-pocket limit set by the ACA, which is higher than allowed for high-deductible health plans.

METHODOLOGY

To help understand what pre-deductible coverage for primary care looks like in individual market plans (excluding plans with cost-sharing reductions), we analyzed the data on non-HDHP plans from the Centers for Medicare & Medicaid Services' (CMS) Exchange Public Use Files (PUFs), specifically the Plan Attributes, Benefits and Cost Sharing, and 2021 OEP State-Level PUFs. (Note that the Exchange PUFs exclude information from state-based exchanges (SBEs) that do not rely on the federal platform for QHP eligibility and enrollment functionality.) We excluded silver plans with CSRs from this analysis because they generally have high actuarial value and very low deductibles.[4] We also excluded HSA-qualified HDHP plans, which represent 5% of plan selections in 2022,[5] because they are prohibited from providing pre-deductible coverage for anything other than preventive care.

COMMON PRACTICES FOR PRE-DEDUCTIBLE COVERAGE IN THE INDIVIDUAL MARKET

Overall, more than 80% of QHPs across metal tiers offer some kind of pre-deductible coverage. Table 2 illustrates the breakdown of pre-deductible coverage available on the exchanges.

Almost all non-HDHP silver-level plans sold on the individual market cover primary care (in excess of required preventive services) and generic drugs without requiring payment towards the deductible. The most common benefit design providing pre-deductible coverage is to apply copayments or coinsurance. Most bronze plans sold on the exchange offer unlimited primary care and generic drugs with pre-deductible coverage in the form of copayments or coinsurance. About 1 in 3 bronze plans, however, offer no or limited pre-deductible coverage (other than preventive care). Silver and gold plans offer significantly more pre-deductible coverage, with 80% offering unlimited visits with pre-deductible coverage in the form of copayments or coinsurance, and only 4% to 5% of such plans excluding pre-deductible coverage.

OFFERING PRE-DEDUCTIBLE COVERAGE HAS IMPROVED OVER TIME

Between 2017 and 2022, QHPs have increasingly offered pre-deductible coverage for primary care visits (Table 3). While bronze plans have significantly increased the availability of pre-deductible coverage for specialist visits and generic drugs, silver and gold plans offer pre-deductible coverage at a significantly higher rate than bronze plans.

Access to medical care on a pre-deductible basis has been associated with increased utilization of necessary care. For example, the elimination of cost-sharing for preventive services under the ACA has been shown to increase utilization of this important care, especially for those who are most financially vulnerable.[6] Research has shown that increased access to primary care reduces hospital admissions as well as avoidable hospital readmissions.[7] Because it leads to more utilization, the emphasis that pre-deductible coverage places on primary care benefits ultimately could result in fewer hospital admissions.

Table 2. Pre-Deductible Benefits in Non-HSA Qualified Individual Market Health Plans, 2022

Plan Details		Percentage of Plans with Specified Pre-Deductible Benefit		
Metal Level	Pre-deductible Benefit	Primary Care	Specialty Visits	Generic Drugs
Bronze	Deductible is not applied	65	41	76
	No pre-deductible coverage	35	59	24
Silver	Deductible is not applied	87	72	86
	No pre-deductible coverage	13	28	14
Gold	Deductible is not applied	94	83	95
	No pre-deductible coverage	6	17	5

*This analysis does not include any health care services beyond those specified in this table (primary care visits, specialty provider visits, and generic drugs). A plan that covers such services without applying the enrollee's deductible likely applies the deductible to other health care services.
**Some plans allow a limited number of provider visits to be covered pre-deductible, either free or with a copay. Plans with this benefit design offer an average of 2-4 visits before applying the deductible

4 A very small percentage of CSR plans have actuarial value of 73% and deductibles of a similar size to non-CSR silver plans. They also are not included in this analysis because there are very few enrollees in this metal level.

5. 4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf (cms.gov)

6..https://journals.sagepub.com/doi/10.1177/10775587211027372

7. See, for example: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5198609/; https://www.ahrq.gov/news/blog/ahrqviews/rethinking-role-of-primary-care.html

Table 3. Cost-Sharing - Percent of QHPs with Common Benefits Covered Before the Deductible

Metal Level	Benefit	2017	2018	2019	2020	2021	2022
Bronze	Primary Care	14%	23%	28%	33%	40%	54%
	Specialist Visit	9%	16%	18%	17%	20%	33%
	Generic Drugs	34%	35%	31%	43%	50%	61%
Silver (Standard)*	Primary Care	71%	71%	77%	82%	83%	84%
	Specialist Visit	59%	56%	62%	66%	62%	69%
	Generic Drugs	82%	76%	81%	85%	85%	83%
Gold	Primary Care	80%	81%	80%	85%	91%	90%
	Specialist Visit	76%	80%	77%	82%	80%	80%
	Generic Drugs	90%	88%	88%	91%	89%	91%

Data taken from Plan Year 2022 Qualified Health Plan Choice and Premiums in HealthCare.gov States, Appendix Tables, CCIIO
*Silver plans represented in this analysis do not include those with cost-sharing reductions applied, which can significantly increase a plan's AV and lower cost-sharing requirements.

MORE THAN HALF OF CONSUMERS ARE ELIGIBLE FOR REDUCED DEDUCTIBLES

The vast majority of consumers who buy insurance on the individual market pay less than the full premium because they are eligible for premium tax credits (PTCs). A significant share of this population receives additional subsidies through CSRs that lower their cost-sharing requirements, such as deductibles, co-payments and coinsurance. For consumers enrolled in health plans on the individual market, average deductibles range from $60 for a platinum plan to $5,388 for a bronze plan (Table 4).

At the end of the 2022 open enrollment period (OEP), 53% of enrollees on the individual market received CSRs to lower their deductibles and other cost-sharing requirements. Over 65% of those receiving CSRs were eligible for plans with AVs of 94%, with average deductibles of $59.[8] Further, because the implementation of the American Rescue Plan Act (ARPA) expanded financial assistance eligibility criteria, deductibles fell even further as more people with incomes that were low enough to qualify for CSR plans purchased coverage: The median deductible for consumers enrolling during the 2022 OEP fell by 65%, from $1,000 in 2019 to $350 in 2022.[9]

Table 4. Average Deductibles, 2021-2022 [10]

	Bronze	Silver	73% AV CSR (Silver)	87% AV CSR (Silver)	94% AV CSR (Silver)	Gold	Platinum	Overall Individual Market	U.S. Employer Sponsored Insurance (Single)**
Share of ACA Enrollment, 2021	$5,388	$3,998	$2,773	$430	$59	$1,396	$60	$2,357	$1,945
Avg. Deductibles, 2021	$6,094	$4,500	$3,115	$530	$69	$1,458	$68	$2,825	$1,931
Share of ACA Enrollment, 2022*	34%	5%	5%***	13%***	35%***	8%	<2%	100%	N/A

* Table excludes catastrophic policies and CSR policies for American Indians and Asia-Pacific Islanders.

** Average deductible for employer-sponsored insurance using 2019 and 2020 employer data.[11]

*** % of total CSR enrollment breakdown only accounts for states using healthcare.gov. All other enrollment data includes all 50 states and the District of Columbia.

8. 2014-2022 OEP Deductibles and HSA Enrollment Public Use File, https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files
9. 2014-2022 OEP Deductibles and HSA Enrollment Public Use File, https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files
10. 2014-2022 OEP Deductibles and HSA Enrollment Public Use File, https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files; and 2022 OEP Sate, Metal Level and Enrollment Status Public Use File, https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files
11. https://www.kff.org/other/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Table 5. Coverage for Catastrophic Health Care Costs

Covered Health Care Costs	Largest Allowable Maximum Out-of-Pocket for 2023	Percent of Health Care Costs Covered by Plan
$100,000	$9,100	90.9%
$500,000	$9,100	98.2%
$1,000,000	$9,100	99.1%

THE ROLE OF HEALTH INSURANCE IN COMBATTING MEDICAL DEBT

Rapid health care cost growth has contributed to medical debt. Recent estimates are that 41% of U.S. adults currently have some level of medical debt.[12] More than half of adults (56%) with medical debt owe less than $2,500, showing just how sensitive consumers are to the cost of medical care. Health insurance acts as a significant buffer between consumers and the cost of medical care. The same research on medical debt noted that people without health insurance coverage are far more likely to have medical debt.

The ACA has decreased medical debt over the last 10 years and added important consumer protection against medical debt.[13] Beyond the AV regulations and financial assistance detailed in this analysis, the ACA ended lifetime and annual dollar limits, protecting the consumer from catastrophic health and financial costs. Additionally, the ACA introduced essential health benefits—10 health services that all health plans must cover—as well as over a dozen services that must be covered without cost-sharing.

While actuarial value represents the average amount of total health care costs covered by a health insurance plan, consumers with catastrophic or chronic health events are further protected by the MOOP—the maximum amount of money an enrollee must pay before their insurance plan will pay for 100% of their covered health care expenses for the remainder of the year. For example, if a consumer experiences a catastrophic health event that requires $500,000 in covered health care costs and they have a plan design with the lowest allowable AV of 60% (bronze with $9,100 deductible and MOOP) would pay $9,100, leaving the individual with an actual AV of 98%. While $9,100 may be a financial barrier for many consumers, the health insurance plan provides a significant safety net relative to the cost of medical services.

Surprise billing has historically been a major source of medical debt in the United States. A consumer may be charged a bill—typically a very large one—for services they received from a health care provider or facility that they did not know was out-of-network and, therefore, not covered under their in-network cost-sharing requirements, at a minimum, leaving the consumer exposed to higher out-of-network cost-sharing requirements and potentially on the hook for the entire cost of the service. With the passage of the No Surprises Act, which became effective Jan. 1, 2022, consumers are now protected against these types of bills for emergency treatment or when out-of-network care is provided at an in-network hospital.

CONCLUSION

Health insurers have provided more generous pre-deductible coverage in their insurance product offerings in the individual market within the constraints of actuarial value and other requirements. While consumers enjoy increased access to QHPs that provide free preventive services and many services before meeting the deductible, major challenges remain in consumer understanding of what pre-deductible coverage is available to them. Further considerations to increase consumer understanding of individual market offerings should include increased outreach and education with an emphasis on health literacy and use of existing online tools, such as out-of-pocket calculators, as well as concerted efforts to clearly define and display health insurance products on exchange websites in a way that promote positive consumer decision-making.

12. https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/
13 https://pubmed.ncbi.nlm.nih.gov/34283184/

Health Insurers Face Major Challenges Offering Pre-deductible Coverage for HDHPs

Due to AV and HSA restrictions on QHPs, health insurers face major challenges in designing benefits for bronze-level plans that include pre-deductible coverage and have low monthly premiums for consumers. The HSA rules that govern the availability of pre-deductible services of an HSA-eligible HDHP were implemented in 2004, well before the implementation of the ACA created a consistent, systematic framework for measuring the generosity of health benefits programs known as AV. Additionally, these rules predate increased focus on chronic condition management and addressing social determinants of health (SDOH) as important aspects of health benefits. This has created an unfortunate situation in which an HSA-ineligible bronze plan can provide targeted pre-deductible services, but an HSA-eligible bronze plan that provides the same overall level of benefits cannot.

Additionally, the structure of HSA-eligible HDHPs prevents health plans from making investments in enrollees' health that improve health while also preventing higher health care costs in the future, such as chronic condition management and addressing certain SDOH. Modernizing the HSA/HDHP rules by defining HDHPs by actuarial value would allow health plans to adapt to consumers' needs while still limiting HSA eligibility to individuals who enroll in plans with high levels of cost-sharing.

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