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STUDY OF THE IMPACT OF LEVEL FUNDED PLANS ON PENNSYLVANIA'S SMALL GROUP ACA MARKET

Prepared for the Pennsylvania Insurance Department

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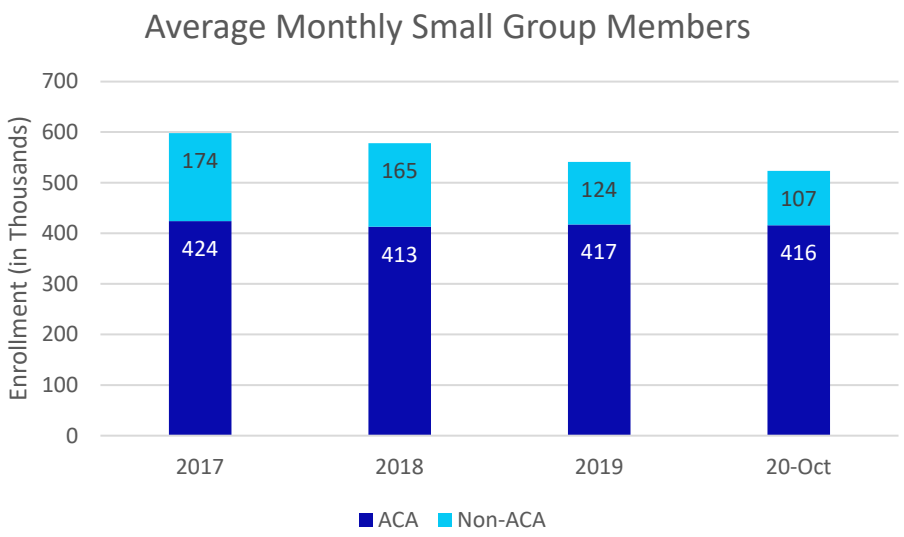
1. EXECUTIVE SUMMARY

The Pennsylvania (PA) fully insured Small Group market has experienced a decline in membership in recent years, shrinking by approximately 12% between the time period of calendar year 2017 and October 2020. To the extent that membership volumes in the PA Small Group market continue to decline, there is an increased risk that the market will become less stable and that premium rates will begin to rise at a quicker rate than has been observed historically (due to a greater likelihood of adverse selection). One item that could lead to a continued decline in membership in the PA fully insured Small Group market is the increased availability of alternative coverage types.

As a result, the Pennsylvania Insurance Department (PID) engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman), with policy support from Manatt Health Strategies (Manatt), to study the potential impact that Level funded Plans (LFP) could have on future enrollment and average premium rates in the PA Small Group Affordable Care Act (ACA) market. This report presents a summary of our analysis and provides potential policy options that the PID may consider which could mitigate the impact that LFPs may be expected have on future Small Group ACA enrollment and premium rate levels.

Chart 1.1 summarizes average monthly Small Group membership in Pennsylvania from calendar year 2017 through October 2020, split by ACA and non-ACA (i.e., Grandfathered and Transitional plans) members. During the specified time period, average enrollment in the PA Small Group market consistently declined each year and, in total, decreased by approximately 75,000 members, or by about 12%, as previously noted.

Chart 1.1



Overall, we estimate that LFPs could have a significant impact on enrollment and premium levels in the PA Small Group ACA market in the future.

One of the factors that affects the magnitude of the impact that LFPs may be expected to have on the PA Small Group ACA market is how aggressively carriers underwrite their LFP products. Carriers offering LFP plans to small groups may choose to be more aggressive in underwriting in order to attract a significant volume of what they perceive to be the healthiest small groups or, conversely, may be more conservative in

their underwriting to ensure that the small groups with employees who have potential health conditions are not issued at rates that are too low.

Table 1.1 summarizes the estimated impact of LFPs to membership volumes and premium rates in the Small Group ACA market under the two underwriting scenarios we modeled. In both scenarios, it was assumed that all groups are issued an LFP with an Individual Stop Loss (ISL) attachment point equal to $20,000 and an Aggregate Stop Loss (ASL) attachment point equal to 110% of expected claims. Under the "Moderate" underwriting scenario, it is estimated that membership in the PA Small Group ACA market would decrease by approximately 19,300 members, or 4.7% of current membership levels, and result in an increase to the Small Group ACA premium rates of 2.8%.[1] Under the "Aggressive" underwriting scenario, it is estimated that membership in the Small Group ACA market would decrease by approximately 47,300 members, or 11.6% of current membership levels, and result in an increase to the Small Group ACA premium rates of 7.3%.

Table 1.1 – Estimated Impact of LFPs on Small Group ACA Members by Underwriting Scenario

Underwriting Scenario	ISL	ASL	Change in Small Group ACA Members	% Change in Small Group ACA Members	Change in Small Group ACA Premium Rates
Moderate	$20,000	110%	-19,300	-4.7%	+2.8%
Aggressive	$20,000	110%	-47,300	-11.6%	+7.3%

The estimated impact that LFPs could have on the PA Small Group ACA market also varies by what ISL and ASL attachment points are assumed to be made available to small employers in the PA LFP market. Table 1.2 summarizes the estimated membership and premium impact to the PA Small Group ACA market under a variety of ISL and ASL attachment point scenarios.

Table 1.2 – Estimated Impact of LFPs on Small Group ACA Members by ISL and ASL

ISL	ASL	Underwriting Scenario	Change in Small Group ACA Members	% Change in Small Group ACA Members	Change in Small Group ACA Premium Rates
$10,000	110%	Aggressive	-38,500	-9.4%	+6.0%
$20,000	110%	Aggressive	-47,300	-11.6%	+7.3%
$20,000	120%	Aggressive	-35,400	-8.6%	+5.5%
$20,000	130%	Aggressive	-25,700	-6.3%	+4.0%

All else equal, as the ISL attachment point increases, the estimated LFP premium rate decreases by more than the increase to the expected out-of-pocket cost to employers. As a result, if higher ISL attachment points are utilized in the PA LFP market, we estimate that more members would exit the PA Small Group ACA market for LFP coverage, and premium rates in the Small Group ACA market would correspondingly increase at a higher rate.[2] Overall, we estimate that membership in the Small Group ACA market would

[1] Estimated premium impact reflects the change in allowed claims PMPM normalized for demographics and geography.

[2] It is possible that some groups may be more risk averse than others and be less inclined to enroll in an LFP plan with a very high ISL attachment point. The comparison utilized to determine which groups may choose to leave the Small Group ACA market and enroll in LFP coverage was only based on a comparison of premium rates and did not consider potential differences in perceived risk aversion among groups.

decrease by approximately 38,500 members, or 9.4% of current membership levels, and result in an increase to PA Small Group ACA premium rates of 6.0% if every carrier offering LFPs in PA were to issue coverage with a $10,000 ISL attachment point and an ASL attachment point equal to 110% of expected claims. However, if the ISL attachment point that were issued by each carrier were to increase to $20,000 while keeping the ASL attachment point equal to 110% of expected claims, we estimate that membership in the Small Group ACA market would instead decrease by approximately 47,300 members, or 11.6% of current membership levels, and result in an increase to PA Small Group ACA premium rates of 7.3%.

Conversely, increasing the ASL attachment point increases the fixed, monthly premium amount that is required of the employer to fund their potential maximum liability under LFP coverage. As a result, when the ASL attachment point is increased, our modeling suggests that less members would exit the Small Group ACA market to enroll in LFPs.

As shown, there is potential for LFPs to significantly impact enrollment and premium rates in the Small Group ACA market. Potential policy options that could be considered that would be expected to impact the migration of small employers from the PA Small Group ACA market to LFPs include the following:

1. **Prohibit Stop-Loss Insurance to Employers Below a Specified Group Size** - The most straightforward policy option that would be expected to impact the future migration of small employers from the Small Group ACA market to LFP coverage would be to prohibit the ability for employers below a specified group size from purchasing stop loss coverage.

2. **Minimum Stop Loss Coverage Attachment Points** - A second policy option would be to regulate attachment points. To the extent minimum attachment points for small employer stop loss coverage were to be prescribed in Pennsylvania, the change would be expected to have two impacts:

    I. The higher the minimum required ASL attachment point, the greater each groups' maximum annual potential liability becomes (assuming they purchase ASL coverage at the minimum amount that is allowed), which correspondingly increases the fixed, level monthly premium amount the employer is required to pay for LFP coverage. In general, this change would be expected to result in fewer groups switching from ACA coverage to LFP coverage, as was demonstrated in the modeling results presented in Table 1.2;

    II. As the minimum ISL and ASL attachment points increase, the percentage of claims expected to be retained by the employer increases; as a result, the higher the stop loss attachment points are, the more likely it is that stop loss coverage would be perceived as carrying more risk than traditional small group health insurance coverage

2. INTRODUCTION

The Pennsylvania (PA) fully insured Small Group market has experienced a decline in membership in recent years, shrinking by approximately 12% between the time period of calendar year 2017 and October 2020. To the extent that membership volumes in the PA Small Group market continue to decline, there is an increased risk that the market will become less stable and that premium rates will begin to rise at a quicker rate than has been observed historically (due to a greater likelihood of adverse selection). One item that could lead to a continued decline in membership in the PA fully insured Small Group market is the increased availability of alternative coverage types.

As a result, the Pennsylvania Insurance Department (PID) engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman), with policy support from Manatt Health Strategies (Manatt), to study the potential impact that Level funded Plans (LFP) could have on future enrollment and average premium rates in the PA Small Group Affordable Care Act (ACA) market.

This report presents a summary of our analysis related to the estimated impact that LFPs could have on enrollment and average premium rates in the PA Small Group ACA market in future years. In addition, this report includes the following:

- An overview of the PA Small Group market, including distributions of membership by age, gender, geography, and industry, as well as changes in enrollment in recent years;

- Potential policy options that the PID may consider which could mitigate the impact that the LFPs may be expected have on future Small Group ACA enrollment and premium rate levels

It is important to note that Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that the PID secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

3. DATA SOURCES AND RELIANCE

We analyzed information from a variety of sources in assessing the PA Small Group market. A list of the key data sources that were used in performing our analysis is summarized below:

- A data call was sent to carriers that offer fully insured comprehensive major medical health insurance coverage in the PA Small Group market. The data that was provided included group level information such as employer coverage type (e.g., ACA, Transitional), geographic location, and industry; member counts by age band and gender for each group; average employee and member counts for each group; and premium and claims cost for each group. Data for two time periods including the 12 months following each group's respective effective/renewal date that occurred between April 2018 and March 2019 (i.e., Analysis Year or AY), and data limited to the month of October 2020, were provided;

- Calendar year 2020 and 2021 rate filing information (e.g., Unified Rate Review Template data);

- Calendar year 2018 and 2019 medical loss ratio (MLR) data;

- Calendar year 2017, 2018, and 2019 summary reports on risk adjustment transfers in the ACA market

Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of the data may not reveal errors or imperfections, and we have assumed that the data is both accurate and complete. The results of our analyses are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

4. PENNSYLVANIA FULLY INSURED SMALL GROUP MARKET OVERVIEW

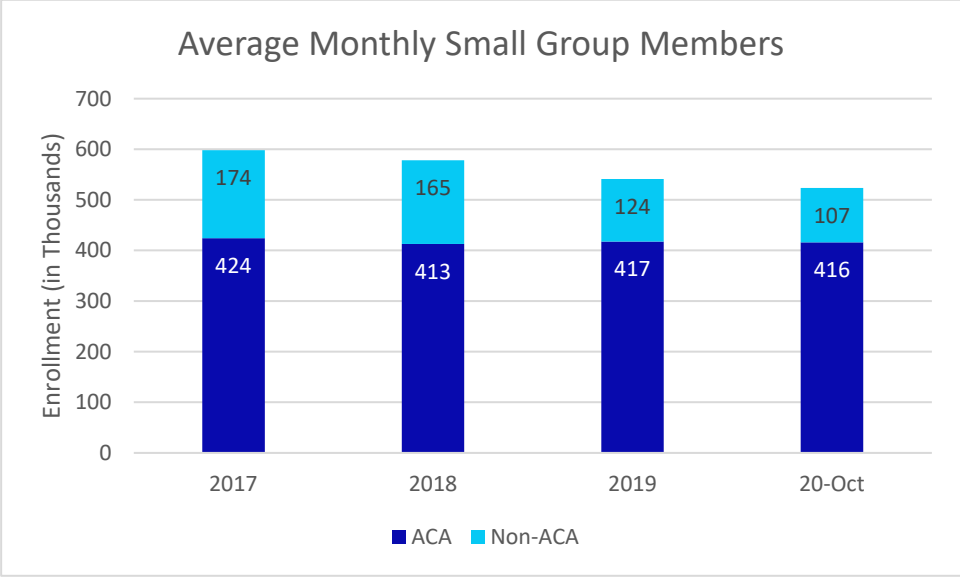
The fully insured comprehensive major medical Small Group health insurance market in Pennsylvania is currently comprised of ACA-compliant plans and Transitional plans (i.e., health plans issued between March 23, 2010 and the end of 2013). There are no Grandfathered plans (i.e., health plans issued prior to March 23, 2010 and have not experienced changes that significantly change covered benefits or increase cost sharing to consumers) remaining in the PA Small Group market as of the end of 2019. Additionally, data associated with groups enrolled in self-insured or any other coverage types was not provided through the carrier data call; as a result, this section of the report is limited to an overview of the fully insured PA Small Group market.

4.1 Small Group Enrollment Volumes

Chart 4.1 summarizes average monthly Small Group member counts in Pennsylvania from calendar year 2017 through October 2020, split by ACA and non-ACA (i.e., Grandfathered plans through 2019 and Transitional plans) members. Over this time period, average enrollment in the PA Small Group market consistently declined each year and, in total, decreased by approximately 75,000 members, or by about 12%. As shown, most of that change was due to a decline of membership in non-ACA plans.

More recently, average enrollment in the PA Small Group ACA and Transitional markets decreased by approximately 18,000 members from calendar year 2019 to October 2020.

Chart 4.1



While the total membership in the PA Small Group market has declined in recent years, the average volume of membership in the PA Small Group ACA market has remained relatively steady. This is likely due in part to the migration of Transitional and Grandfathered groups into ACA plans over that same time period.

4.2 Small Group Members by Age and Gender

In addition to overall enrollment volumes, the data we received through the carrier data call contained member counts by age band and gender for each group. Chart 4.2 summarizes the distribution of Small Group Transitional and ACA members by age band as of October 2020. As shown, more than 50% of the Small Group membership is age 35 or older. Additionally, we observe that the age distributions are similar between the Transitional and ACA market segments, although the Transitional membership skews somewhat older than the ACA membership.

Chart 4.2

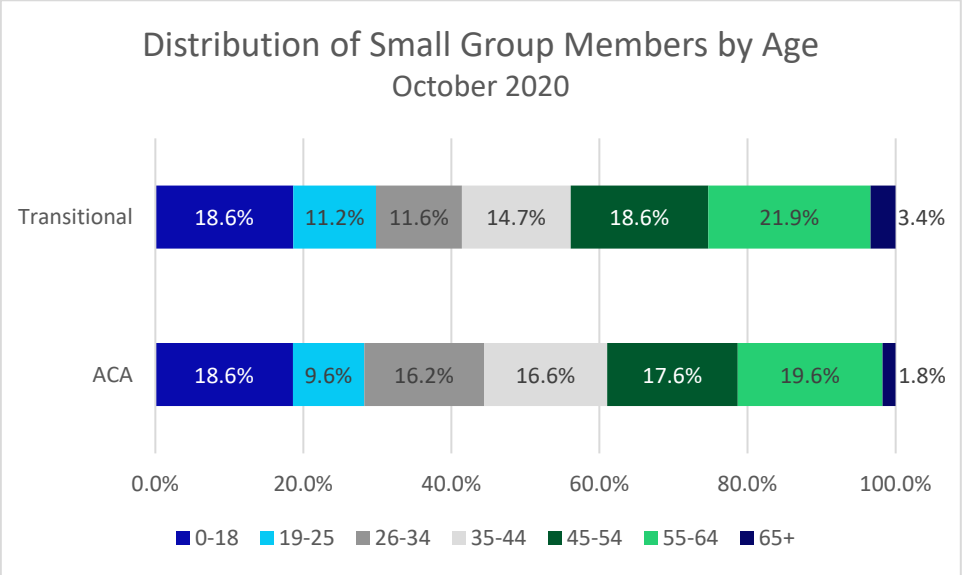
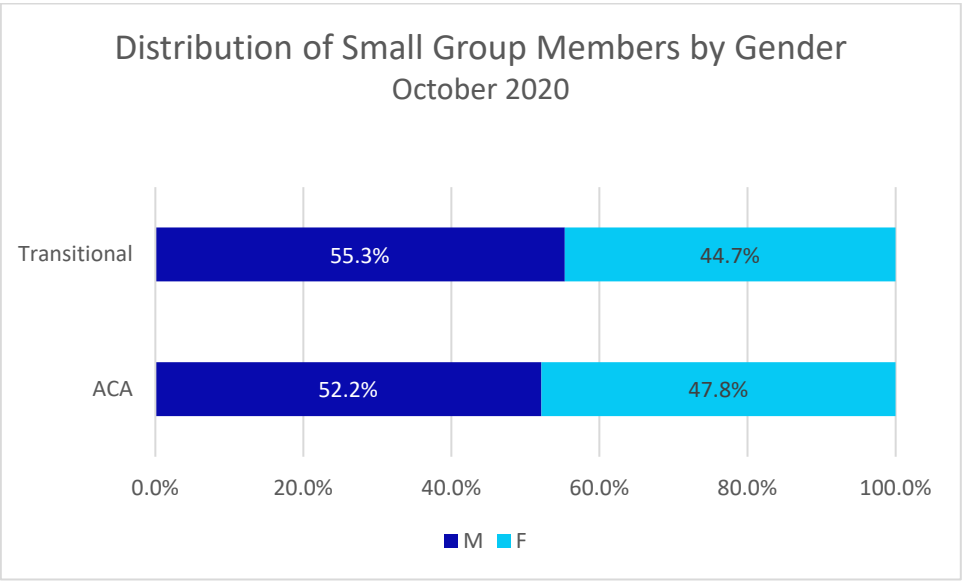


Chart 4.3 summarizes the distribution of Small Group Transitional and ACA members by gender. Again, the distributions are similar, skewing slightly more male than female, although there is a slightly higher percentage of males among the Transitional members than among the ACA members.

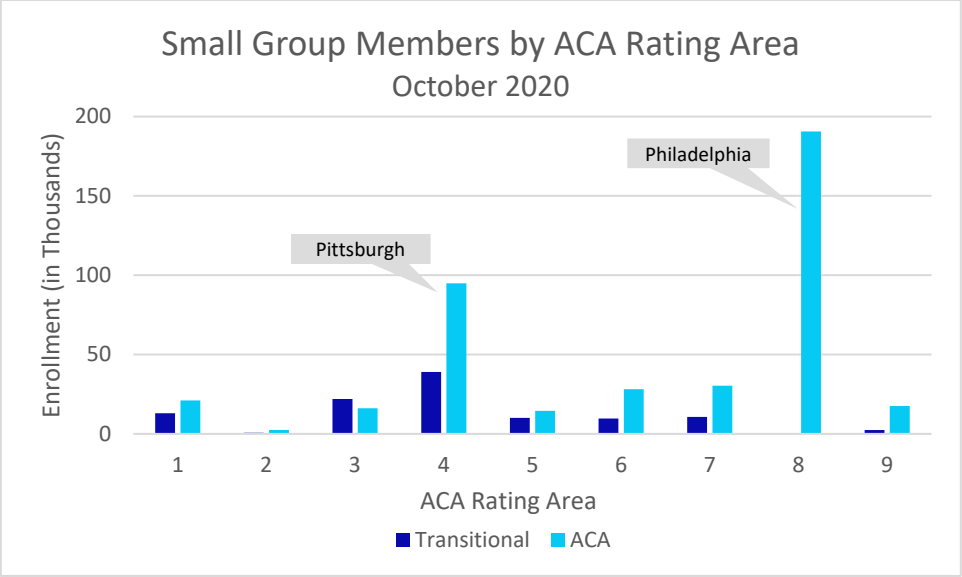
Chart 4.3



4.3 Small Group Members by Geographic Rating Area

The carrier data that was provided included employer zip code and county,[3] which we used to identify each group's corresponding ACA rating area.[4] Chart 4.4 below summarizes the volume of Small Group Transitional and ACA members by ACA rating area as of October 2020. As shown, Rating Areas 4 (Pittsburgh) and 8 (Philadelphia) are by far the largest in terms of enrollment volume, with about 62% of total Small Group fully insured enrollment contained within those two rating areas. Additionally, it can be observed that Rating Areas 3 and 4 contain the highest volumes of Small Group Transitional members as of October 2020, while there are very few Small Group Transitional members remaining in Rating Areas 8 and 9 relative to the total count of members enrolled in the PA Small Group market in those rating areas.

Chart 4.4



4.4 Small Group Members by Industry Type

We were able to use Standard Industrial Classification (SIC) and North American Industry Classification System (NAICS) codes that were provided in the carrier data to identify each group's industry category.[5] Chart 4.5 summarizes the distribution of Small Group Transitional and ACA members by industry, as of October 2020. The largest volume of membership falls within the Services industry which includes businesses such as consulting firms, engineering companies, and hotels. The next largest volumes of membership fall within the Manufacturing and Construction industries. We observe that there is a higher proportion of groups in these two industries (i.e., Construction, Manufacturing) that generally skew towards younger, male employees relative to other industries. This is likely in part because those members may receive more competitive premium rates in the Small Group Transitional market, relative to the PA

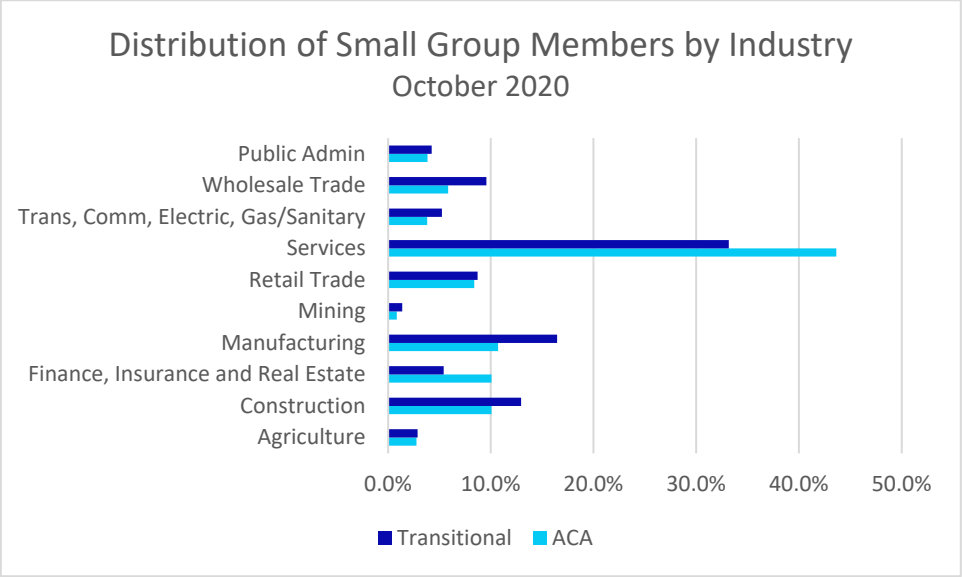
[3] Approximately 0.1% of groups provided in the carrier data were omitted from the analysis because geographic information was were not provided, or a rating area within PA could not be assigned.

[4] A map showing how the state is segmented by ACA rating area can be found in Appendix A. A list of counties within each rating area can be found here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/pa-gra.

[5] Approximately 0.1% of groups provided in the carrier data were omitted from the analysis because industry data were not provided, or an industry could not be assigned.

Small Group ACA market, as Transitional plans are not subject to the prescribed age curve and unisex rating that is required in the ACA market and can be rated based on industry and group health status. [6]

Chart 4.5



[6] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf

5. LEVEL FUNDED PLANS

The objective of the LFP analysis was to estimate which groups currently enrolled in the PA Small Group ACA market may be most likely to choose LFP coverage over Small Group ACA coverage in the future, based on a comparison of modeled premium rates between the two coverage types. Once it was determined which groups may be most likely to choose LFP coverage over Small Group ACA coverage, we then assessed the potential impact that LFPs could have on enrollment and premium rates in the PA Small Group ACA market.

5.1 Background

LFPs are a form of self-funded coverage.[7] One key characteristic of LFPs is that individual stop loss (ISL) and aggregate stop loss (ASL) coverage are both purchased as part of the LFP in order to cap the employer's annual out-of-pocket costs. Another key characteristic of LFPs is that the employer pays a fixed, level monthly premium amount to fund their group's maximum potential liability for the year.[8] This latter characteristic generally makes LFPs unique relative to other types of self-funded arrangements.

Under LFP coverage, the employer's maximum potential liability for the year is calculated as the sum of their administrative fees, ISL premium, ASL premium, and their total potential cost if the group's annual claims were to exceed the ASL attachment point (e.g., 110% of expected claims). Since the group pre-funds their maximum annual potential liability under an LFP, the group's actual costs for the year will often end up lower than the amount that they pre-fund and, in that case, a portion of the amount that was over-funded is generally returned to the group, after the end of the year.

Some advantages to small employers of utilizing LFPs include the following:

1. Due to the pre-funding of the group's maximum potential liability through fixed, level monthly premium payments, LFPs provide small employers with more stable cash flows when compared to other types of self-funding arrangements;
2. To the extent a group's claim costs are expected to be lower than average, their level monthly premium payments may be lower than what they would otherwise be required to pay for Small Group ACA coverage;
3. A group can generate potential savings under an LFP due to being able to avoid paying state premium taxes and covering certain benefits

Some disadvantages to small employers of utilizing LFPs include the following:

1. If the group's claim costs are expected to be higher than average, the group's level monthly premium payments may be significantly higher than what they would be required to pay for Small Group ACA coverage;
2. Groups can be re-underwritten each year and, therefore, their LFP premium payments can be subject to change, sometimes by a significant amount, on a year-to-year basis

[7] Self-funded plans are those in which an employer takes on a large portion of the expected medical costs of their employees as opposed to purchasing traditional comprehensive coverage through a health insurance carrier.

[8] Please see Appendix B for a description of what group-level LFP premium rates include and how they were developed

5.2 Key Assumptions

A list of key assumptions underlying the LFP analysis we completed is summarized below:

- The LFP premium amounts for each group were calculated as follows: LFP premium = group-level expected claims below the ISL attachment point * ASL coverage level (e.g., 110% of expected claims) + ASL premium + ISL premium + expenses;
- In developing estimated premium rates for ASL and ISL coverage, target loss ratios equal to 60% and 70% were assumed, respectively;
- The minimum attachment points carriers can/will use for small employers in Pennsylvania are equal to $10,000 for ISL and 110% of expected claims for ASL;
- LFPs generally cover the same level of benefits as ACA plans;
- An underlying benefit plan consistent with that of a Gold metal plan offered in the Small Group ACA market was assumed for each group;
- When reviewing their ACA plan options, groups consider the lowest-cost 2021 Small Group ACA premium rate for a Gold plan available to them, based on the county in which the group is located;
- Groups will not leave the PA Small Group ACA market for an LFP unless they recognize at least a 5% premium savings

Appendix B at the end of this report contains additional detail regarding the development of the LFP group-level premium amounts.

5.3 Analysis Results

5.3.1 Estimated Impact Under Varying Levels of Underwriting

One of the factors that affects the magnitude of the impact that LFPs may be expected to have on the PA Small Group ACA market is how aggressively carriers underwrite their LFP products. Carriers offering LFP plans to small groups may choose to be more aggressive in underwriting in order to attract a significant volume of what they perceive to be the healthiest small groups or, conversely, may be more conservative in their underwriting to ensure that the small groups with employees who have potential health conditions are not issued at rates that are too low. We approximated the varying levels of underwriting that may be used in the market by assigning either higher or lower credibility to each group's actual historical claims experience in our underlying data. To simulate more "Aggressive" underwriting, we assigned greater credibility to the group-specific experience, resulting in the groups that had the lowest historical claim costs receiving more favorable premium rates for LFP coverage; to simulate more conservative underwriting, we assigned less credibility to each group's actual historical claims experience, resulting in their projected claim costs being closer to the market average, relative to the "Aggressive" scenario.

Table 5.1 summarizes the estimated impact of LFPs on membership volumes and premium rates in the PA Small Group ACA market under the two underwriting scenarios we modeled. The "Moderate" and "Aggressive" underwriting scenarios assume that group-specific experience is fully credible at 100 or more employees and 50 or more employees, respectively. In both scenarios, it is assumed that all groups are issued an LFP plan with an ISL attachment point equal to $20,000 and an ASL attachment point equal to 110% of expected claims. Under the "Moderate" underwriting scenario, it is estimated that membership in the PA Small Group ACA market could decrease by approximately 19,300 members, or 4.7% of current

membership levels, and result in an increase to the PA Small Group ACA premium rates of 2.8%.[9] Under the "Aggressive" underwriting scenario, it is estimated that membership in the PA Small Group ACA market could decrease by approximately 47,300 members, or 11.6% of current membership levels, and result in an increase to the Small Group ACA premium rates of 7.3%.

Table 5.1 – Estimated Impact of LFPs on the Small Group ACA Market by Underwriting Scenario

Underwriting Scenario	ISL	ASL	Change in Small Group ACA Members	% Change in Small Group ACA Members	Change in Small Group ACA Premium Rates
Moderate	$20,000	110%	-19,300	-4.7%	+2.8%
Aggressive	$20,000	110%	-47,300	-11.6%	+7.3%

5.3.2 Estimated Impact Under Varying Levels of ISL and ASL Attachment Points

The estimated impact that LFPs may have on the PA Small Group ACA market also varies based on what ISL and ASL attachment points are assumed to be made available to small employers in the PA LFP market. Table 5.2 summarizes the estimated membership and premium impact to the PA Small Group ACA market under a variety of ISL and ASL attachment point scenarios.

Table 5.2 – Estimated Impact of LFPs on the Small Group ACA Market by ISL and ASL

ISL	ASL	Underwriting Scenario	Change in Small Group ACA Members	% Change in Small Group ACA Members	Change in Small Group ACA Premium Rates
$10,000	110%	Aggressive	-38,500	-9.4%	+6.0%
$20,000	110%	Aggressive	-47,300	-11.6%	+7.3%
$20,000	120%	Aggressive	-35,400	-8.6%	+5.5%
$20,000	130%	Aggressive	-25,700	-6.3%	+4.0%

All else equal, as the ISL attachment point increases, the estimated LFP premium rate decreases by more than the increase to the expected out-of-pocket cost to employers. As a result, if higher ISL attachment points are utilized in the PA LFP market, we estimate that more members would exit the PA Small Group ACA market for LFP coverage, and premium rates in the PA Small Group ACA market would correspondingly increase at a higher rate. [10]

Conversely, increasing the ASL attachment point increases the fixed, monthly premium amount that is required of employer to fund their potential maximum liability under LFP coverage. As a result, when the ASL attachment point is increased, our modeling suggests that less members would exit the PA Small Group ACA market to enroll in LFPs.

[9] Estimated premium impact reflects the change in allowed claims PMPM normalized for demographics and geography.

[10] It is possible that some groups may be more risk averse than others and be less inclined to enroll in an LFP plan with a very high ISL attachment point. The comparison utilized to determine which groups may choose to leave the Small Group ACA market and enroll in LFP coverage was only based on a comparison of premium rates, and did not consider potential differences in perceived risk aversion among groups.

5.3.3 Estimated Impact of LFPs on the Distribution of Small Group ACA Members by Age and Gender

LFPs are not expected to impact Small Group ACA membership by age and gender uniformly. Tables 5.3 and 5.4 summarize the estimated change in the age and gender distributions of the Small Group ACA membership, respectively, under the "Moderate" and "Aggressive" underwriting LFP scenarios that were utilized to produce the results in Table 5.1.

In each scenario, it is estimated that the PA Small Group ACA market would age slightly as small employers that have a younger average demographic mix of employees may receive more competitive premium rates through LFP coverage relative to the PA Small Group ACA market (i.e., due to the 3:1 age rating curve that is required to be utilized in the ACA market and impact of industry rating and underwriting that is allowed for LFP coverage).

Table 5.3 – Estimated Impact of LFPs on the Distribution of Small Group ACA Members by Age ($20,000 ISL, 110% ASL)

Age	Moderate Underwriting	Aggressive Underwriting
0-18	-0.1%	-0.3%
19-25	-0.1%	-0.1%
26-34	-0.4%	-0.7%
35-44	-0.1%	-0.2%
45-54	+0.2%	+0.4%
55-64	+0.4%	+0.8%
65+	0.0%	+0.1%

Additionally, in each scenario, it is estimated that the proportion of females in the PA Small Group ACA market would increase as groups that have a greater proportion of younger, males would be more likely find that their premium rates through LFP coverage are lower relative to the PA Small Group ACA market (due to the unisex rating structure that is required to be utilized in the ACA which is not required for LFP coverage).

Table 5.4 – Estimated Impact of LFPs on the Distribution of Small Group ACA Members by Gender ($20,000 ISL, 110% ASL)

Gender	Moderate Underwriting	Aggressive Underwriting
M	-0.4%	-0.7%
F	+0.4%	+0.7%

5.3.4 Estimated Impact of LFPs on Small Group ACA Members by Rating Area

PA Small Group ACA premium levels vary by rating area, as do the average demographic mix, industry mix, and morbidity levels of groups within PA. As a result, our modeling suggests that LFPs would be expected to impact some rating areas more than others. Tables 5.5 and 5.6 summarize the estimated impacts that migration to LFP coverage under the previously described "Moderate" and "Aggressive" underwriting LFP scenarios, respectively, would be expected to have on Small Group ACA membership in Pennsylvania by rating area.

Table 5.5 - Estimated Impact of LFPs on Small Group ACA Members by Rating Area
"Moderate Underwriting" LFP Scenario
($20,000 ISL, 110% ASL)

Rating Area	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
1	-700	-3.8%
2	-400	-16.1%
3	-400	-2.6%
4	-2,700	-2.9%
5	-1,400	-9.9%
6	-400	-1.4%
7	-400	-1.7%
8	-12,800	-6.7%
9	-100	-0.3%
Total	**-19,300**	**-4.7%**

[1] Rounded to the nearest hundred, and may not sum to the total due to rounding

Table 5.6 - Estimated Impact of LFPs on Small Group ACA Members by Rating Area
"Aggressive Underwriting" LFP Scenario
($20,000 ISL, 110% ASL)

Rating Area	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
1	-2,100	-12.1%
2	-600	-26.8%
3	-1,200	-8.0%
4	-8,200	-9.0%
5	-2,300	-16.4%
6	-2,100	-6.8%
7	-1,200	-4.4%
8	-28,500	-14.8%
9	-1,000	-5.3%
Total	**-47,300**	**-11.6%**

[1] Rounded to the nearest hundred, and may not sum to the total due to rounding

As shown in Tables 5.5 and 5.6, enrollment in Rating Area 8, which is the most populated rating area in the PA Small Group ACA market, is estimated to decrease by approximately 12,800 under the "Moderate" underwriting scenario and by 28,500 members under the "Aggressive" underwriting scenario, respectively. Upon reviewing the results further, we observe that groups enrolled in the PA Small Group ACA market in Rating Area 8 are generally younger and employed in industries that may find LFP premium rates more competitive than ACA coverage. Groups in Rating Areas 2 and 5 are also projected to be impacted significantly by the availability of LFP coverage; however, those two rating areas are significantly smaller than Rating Area 8 in terms of enrollment volume and, therefore, not expected to be as impactful to the overall PA Small Group ACA single risk pool.

5.3.5 Estimated Impact of LFPs on Small Group ACA Members by Industry

In general, it is expected that the availability of LFPs would have a greater impact on industries that skew younger, skew more male, and generally would be expected to have lower average claim costs. Our analysis confirms this, as our results suggest that LFPs would be most likely to impact industries such as construction and agriculture relative to others. Tables 5.7 and 5.8 summarize the estimated membership impact by industry under the "Moderate" and "Aggressive" LFP scenarios, respectively, that we described earlier.

Table 5.7 - Estimated Impact of LFPs on Small Group ACA Members by Industry "Moderate Underwriting" LFP Scenario ($20,000 ISL, 110% ASL)

Industry	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
Agriculture	-900	-7.7%
Construction	-3,200	-7.7%
Finance, Insurance and Real Estate	-2,300	-5.6%
Manufacturing	-2,000	-4.6%
Mining	-200	-6.1%
Retail Trade	-1,800	-5.2%
Services	-7,200	-4.0%
Trans, Comm, Electric, Gas/Sanitary	-300	-2.0%
Wholesale Trade	-1,200	-5.1%
Public Admin	-100	-0.7%
Total	**-19,300**	**-4.7%**

[1] Rounded to the nearest hundred, and may not sum to the total due to rounding

Table 5.8 - Estimated Impact of LFPs on Small Group ACA Members by Industry "Aggressive Underwriting" LFP Scenario ($20,000 ISL, 110% ASL)

Industry	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
Agriculture	-2,000	-17.4%
Construction	-6,600	-16.0%
Finance, Insurance and Real Estate	-5,400	-13.2%
Manufacturing	-5,200	-11.8%
Mining	-600	-16.0%
Retail Trade	-3,800	-11.1%
Services	-18,800	-10.5%
Trans, Comm, Electric, Gas/Sanitary	-1,400	-8.9%
Wholesale Trade	-2,700	-11.5%
Public Admin	-800	-5.3%
Total	**47,300**	**-11.6%**

[1]Rounded to the nearest hundred, and may not sum to the total due to rounding

5.3.6 Estimated Impact of LFPs on Small Group ACA Members by Group Size

Claim costs that are associated with larger groups tend to be more stable and predictable, relative to smaller employers; as a result, the larger small groups (i.e., small groups with more than 10 employees) that have had favorable claims experience may be expected receive lower LFP premium rates (i.e., than smaller small groups with similar experience) due to the increased credibility that would be placed on that group's claims experience. Conversely, the smallest small groups would be expected to more often be rated at an average market cost level and/or see greater risk margins incorporated into their expected claim costs due to anticipated year-to-year volatility. Tables 5.9 and 5.10 summarize the estimated membership impact under the "Moderate" and "Aggressive" underwriting LFP scenarios that we described earlier. Overall, our modeling suggests that LFPs are expected to have the greatest impact on the Small Group ACA membership that is associated with the largest small groups.

Table 5.9 - Estimated Impact of LFPs on Small Group ACA Members by Group Size
"Moderate Underwriting" LFP Scenario
($20,000 ISL, 110% ASL)

Group Size	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
1	-100	-0.6%
2-9	-2,200	-1.1%
10-25	-9,800	-7.2%
26+	-7,200	-13.5%
Total	**-19,300**	**-4.7%**

[1]Rounded to the nearest hundred, and may not sum to the total due to rounding

Table 5.10 - Estimated Impact of LFPs on Small Group ACA Members by Group Size
"Aggressive Underwriting" LFP Scenario
($20,000 ISL, 110% ASL)

Group Size	Change in Small Group ACA Members[1]	% Change in Small Group ACA Members
1	-200	-1.3%
2-9	-8,100	-3.9%
10-25	-26,200	-19.4%
26+	-12,800	-24.0%
Total	**-47,300**	**-11.6%**

[1]Rounded to the nearest hundred. and may not sum to the total due to rounding

5.4 Policy Considerations

In this section, we discuss potential policy options that could be considered by the PID that would be expected to impact the migration of small employers from the PA Small Group ACA market to LFP coverage in the future.

1. Prohibit Stop-Loss Insurance to Employers Below a Specified Group Size

The most straightforward policy option that would be expected to impact the future migration of small employers from the PA Small Group ACA market to LFP coverage would be to prohibit the ability for employers below a specified group size from purchasing stop loss coverage. Given that stop loss coverage is a necessary component of LFPs, to the extent small employers below a specified group size were prohibited from purchasing stop loss coverage, they would in turn not be able to utilize LFPs.

Per Tables 5.9 and 5.10, our modeling suggests that LFPs are expected to have the greatest impact on the largest group sizes in the PA Small Group ACA market (i.e. those groups that have 10-25 and 26+ employees are most likely to select LFPs over ACA coverage). Therefore, if a policy objective were to be to mitigate the future potential migration of small employers out of the PA Small Group ACA market to the greatest extent possible, prohibiting the sale of stop-loss insurance to all small groups (i.e., groups with 50 full-time employees or less) may be necessary.

Examples of states that currently prohibit stop-loss insurance to employers below a specified group size include New York and Delaware. New York prohibits the sale of stop-loss insurance to employers with 50 or fewer employees.[11] Delaware prohibits the sale of stop-loss insurance to employers with five or fewer employees and also requires that employers who purchase stop-loss coverage have a majority of their employees located within the state.[12]

2. Minimum Stop Loss Coverage Attachment Points

A second policy option would be to regulate attachment points. As discussed earlier, one key characteristic of LFPs is that Individual Stop Loss (ISL) and Aggregate Stop Loss (ASL) coverage is purchased by the employer in order to set a cap on the group's maximum annual potential liability. Another key characteristic associated with LFPs is that the employer pays a fixed, level monthly premium amount equal to the group's maximum annual liability for the year divided by twelve.

To the extent minimum attachment points for small employers who purchase stop loss coverage were to be prescribed in Pennsylvania, the change would be expected to have two impacts:

1. ASL attachment points are typically specified as a percentage of expected claims (e.g., 110% of expected claims). The higher the minimum required ASL attachment point is, the greater each groups' maximum annual potential liability becomes, which correspondingly increases the fixed, level monthly premium amount the employer is required to pay for LFP coverage. In general, prescribing a higher minimum ASL attachment point would be expected to result in fewer groups switching from ACA coverage to LFP coverage, as was demonstrated in the modeling results that are presented in Table 5.2.
2. As the minimum ISL and ASL attachment points increase, the percentage of claims that would be expected to be retained by the employer increases; as a result, the higher the stop loss attachment points are, the more likely it is that stop loss coverage would be perceived as carrying more risk than traditional small group health insurance coverage.

[11] https://www.nysenate.gov/legislation/laws/ISC/4317
[12] https://delcode.delaware.gov/title18/c072/index.html

For reference, several states have adopted minimum stop loss attachment points to-date,[13] and a number of those states have adopted minimum standards that are consistent with the NAIC Stop Loss Insurance Model Act which states the following:

A carrier may not issue a stop-loss policy with an attachment point:

1. lower than $20,000 per individual;
2. for groups of 50 or fewer, lower than the greater of (1) $4,000 times the number of members, (2) 120% of expected claims, or (3) $20,000; or
3. for groups of 51 or more, lower than 110% of expected claims.

[13] https://content.naic.org/sites/default/files/model-law-92-stop-loss-model.pdf

6. ACKNOWLEDGEMENT OF ACTUARIAL QUALIFICATIONS

The Commonwealth of Pennsylvania engaged Oliver Wyman Actuarial Consulting, Inc. to study the potential impact that LFPs could have on future enrollment and average premium rates in the PA Small Group ACA market.

Ryan Schultz, Taylor Gehrke, and Tammy Tomczyk, all Fellows of the Society of Actuaries, are responsible for this actuarial communication. They are all Members of the American Academy of Actuaries and meet the requirements to issue this report.

For our modeling and analysis, we relied on a wide range of data and information as described throughout this report. This includes information received from carriers currently offering coverage in the Small Group market in Pennsylvania. Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of the data may not reveal errors or imperfections. We have assumed the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

The estimates included within are based on federal law, regulations issued by the United States Department of Health and Human Services and the Internal Revenue Service, and applicable laws and regulations of Pennsylvania. Further, our estimates assume that current law as it relates to the ACA, and other statutes and regulations that impact the health insurance markets, will continue in the future years without material change that would impact the results included in this report.

While this analysis complies with the applicable Actuarial Standards of Practice, in particular ASOP No. 23, Data Quality, and ASOP No 41, Actuarial Communication, users of this analysis should recognize that our results involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. We have not anticipated any extraordinary changes to the legal, social, or economic environment that might affect our estimates.

For these reasons, no assurance can be given that the emerging results will correspond to the estimates in this analysis. To the extent future conditions differ from the assumptions we have made in developing these estimates, actual results will vary from our estimates, and the variance may be substantial.

7. CAVEATS AND LIMITING CONDITIONS

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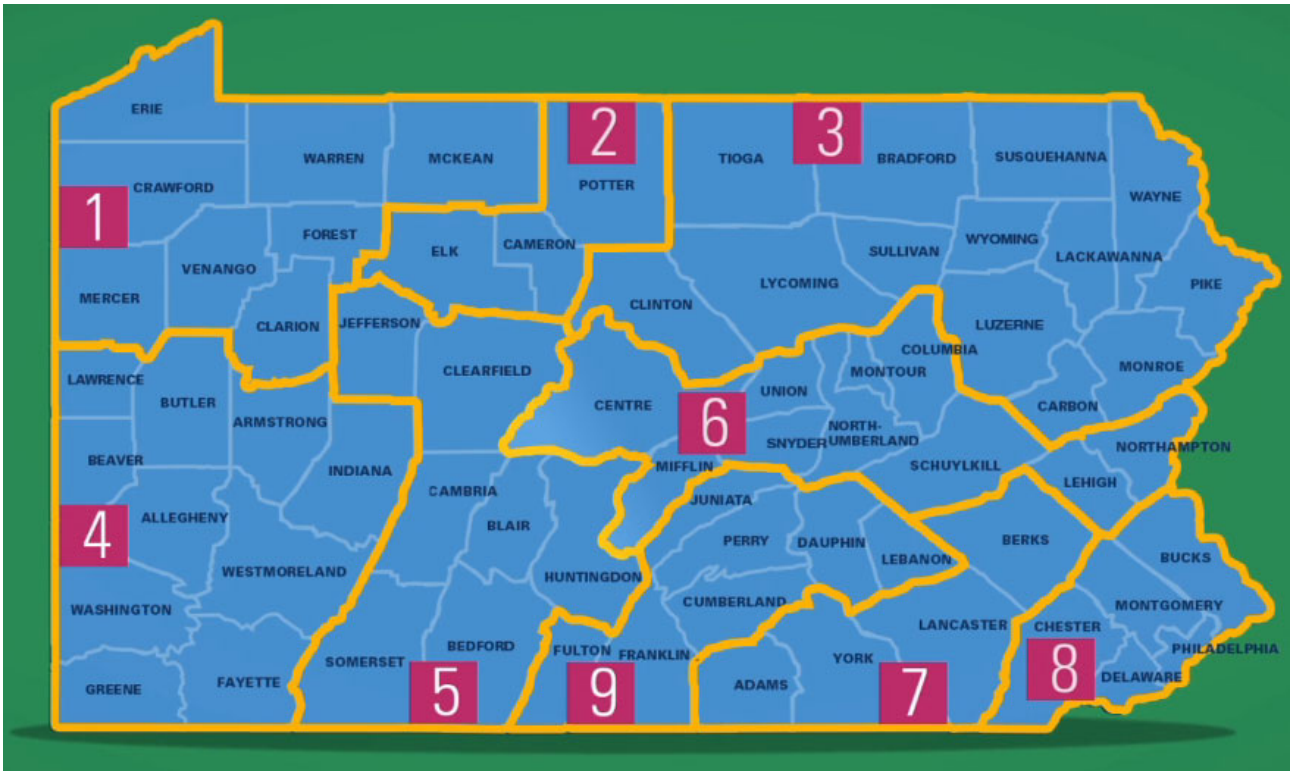
All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the Commonwealth of Pennsylvania. This report does not represent investment advice, nor does it provide an opinion regarding the fairness of any transaction to any and all parties.

APPENDIX A – MAP OF PENNSYLVANIA ACA RATING AREAS



Source: https://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/Rating-Area-Charts.aspx

APPENDIX B – LEVEL FUNDED PLAN PREMIUM DEVELOPMENT METHODOLOGY

A detailed description of the group-level LFP premium calculation that was utilized in the LFP analysis is described below:

- Group-level LFP premium = group-level expected claims below ISL * ASL attachment point (e.g., 110% of expected claims below ISL) + estimated ASL premium + estimated ISL premium + assumed expenses
    - Group level expected claims below ISL = credibility weighted group level actual incurred claims and the manual rate
        - Group level actual claims were trended to 2021 using a 7.0% annualized trend rate (assessed for reasonability using the 2021 Small Group ACA Unified Rate Review Templates)
        - A range of credibility assumptions were considered; ultimately, 50 covered employees were assumed to be fully credible under an "Aggressive" underwriting scenario and 100 covered employees were assumed to be fully credible under our "Moderate" underwriting scenario
        - A manual rate was calculated as the average allowed claims PMPM across the entire PA Small Group market, normalized for demographics, geography, group size, and industry
            - Demographic Adjustment: Based on a claim-based age/gender curve from a large commercial proprietary database
            - Geography: Based on Small Group ACA geographic cost factors used for CMS' 2019 benefit year risk adjustment transfer calculation[14]
            - Group size: Calculated factors informed from prior experience working with LFP products
            - Industry: Calculated via actual claim cost relativities per Small Group experience provided by Pennsylvania carriers, normalized for demographics, geography, and group size differences
                - We were unable to normalize for differences in network, product, or induced utilization with the data available, so the industry factors may include some impact of differences in these items
            - Claim costs were converted to an incurred basis via an assumed market average paid-to-allowed ratio of 85% (reflective of benefit levels observed in the PA Small Group ACA market based on experience data provided by Pennsylvania carriers)
    - Estimated ASL premium:
        - For each group, we developed an expected ASL ceded claims amount based on simulated runs from a proprietary model for groups of a similar size and the magnitude of the group's average expected incurred claims PMPM
        - A 60% target loss ratio was assumed for the ASL product

[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

- Estimated ISL premium:
  - For each group, we developed an expected ISL ceded claims amount based on simulated runs from a proprietary model for groups of a similar size and the magnitude of the group's average expected incurred claims PMPM
  - A 70% target loss ratio was assumed for the ISL product
- Assumed expenses:
  - We assumed $50 PEPM for administrative expenses based on actuarial judgement and industry experience
  - We assumed $30 PEPM for broker fees based on actuarial judgement and industry experience

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