Pennsylvania Plan Year 2025
Affordable Care Act and Qualified Health Plans
Summary Report

Pennsylvania
Insurance Department

Office of Product Regulation
Bureau of Life, Accident, and Health Insurance Rate and Policy Form Review

Summary Report Issued November 2024

Contents

Pennsylvania's Health Insurance Market

Pennsylvanians receive healthcare coverage through different programs and providers. Medical Assistance and Medicare make up 43% of the market; 27% of the market is made up of self-funded plans overseen by the U.S. Department of Labor; and 25% of the comprehensive major medical insurance plans are submitted to the Pennsylvania Insurance Department (PID) for approval prior to being sold in the commercial market. These plans include those offered on Pennie®, PA's official health insurance marketplace, student health plans offered through universities and colleges, and those sold in the small and large employer markets.

PID's Office of Insurance Product Regulation is generally responsible for reviewing and regulating insurance policies sold in Pennsylvania.

Qualified Health Plans Meet Essential Health Benefit Standards

The Patient Protection and Affordable Care Act of 2010 (ACA) outlines coverage requirements for major medical health insurance. Under the ACA, the federal Department of Health and Human Services (HHS) issued regulations that define the Essential Health Benefits (EHB) based on state-specific benchmark plans. The benchmark plan sets the minimum coverage requirements a health insurance plan must offer to be considered a Qualified Health Plan (QHP) under the ACA. The current benchmark plan for Pennsylvania is the Gold Premier HMO by Keystone Health Plan East.

The minimum coverage categories are established as ten Essential Health Benefits (EHB) which include:

Outpatient Services

Emergency Services

Hospitalization

Maternity and Newborn Care

Mental/Behavioral Health and Substance Use Disorder Services

Prescription Drugs

Rehabilitative and Habilitative Services and Devices

Laboratory Services

Preventive and Wellness Services and Chronic Disease Management

Pediatric Services (including oral and vision care)

All plans sold in the Pennsylvania commercial market have been reviewed for compliance with state and federal laws and regulations. This includes reviewing the rates for adequacy, validating mandatory benefits are covered, formulary analysis, mental health parity, and network adequacy testing.

Companies Selling Commercial Coverage in Pennsylvania

Addressing Health Insurance Consumer Complaints

PID's Office of Market Regulation monitors and addresses consumer services complaints and inquiries. More than two thirds or 66% of health insurance complaints and inquires have to do with claims handling, which includes, but is not limited to claims denials, issues with copays, deductibles, or coinsurance, balanced billing, and claims delays. Other complaint and inquiry topics include, but are not limited to, autism coverage, mental health, substance use disorder, or involve consumers looking for help to better understand their insurance benefits.

Denied Claims and Appeals

Insurers selling plans in the individual market must submit claim denial and appeal information as reported under the Transparency in Coverage (TiC) rules of the ACA. The TiC data shows that approximately [15,000,000] claims were submitted in 2023, where over [2,000,000] or [14%] are denied each year in the individual market. Most notable, less than 1% of those denied claims were appealed by consumers or their healthcare providers (on the consumer's behalf) despite the fact that over 50% of these denials are overturned by an internal or external appeal. The TiC comprehensive reports are available on PID's website: Transparency Coverage Report for ACA Health Plans.

Provider Network Adequacy

As required in federal law and regulation, a QHP issuer must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. Regulators review all networks using federal and state time and distance standards, generally referencing the requirements in Act 68 of 1998, as amended by Act 146 of 2022, 28 Pa. Code Ch. 9, and 45 C.F.R. § 156.230 as amended by the final 2024 Notice of Benefit and Payment Parameters.

When the federal or state standards conflict, regulators utilize the standards that are the most stringent and provide the most consumer protection. The Center for Medicare and Medicaid Services (CMS) has classified each of Pennsylvania's counties into one of five county type designations: Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC). In Pennsylvania, there are no counties classified as CEAC, however there are 13 counties classified as Rural: Bedford, Cameron, Clinton, Elk, Forest, Fulton, Huntingdon, McKean, Potter, Sullivan, Susquehanna, Tioga, and Warren. Pennsylvanians living in rural counties may have to drive longer distances to see healthcare providers than those living in micro, metro, or large metro counties.

Regulators assess health insurer networks to ensure that they provide access for at least 90% of their enrollees. Each network is analyzed at a state and county level to ensure it meets the 90% threshold. As insurers expand into new counties or when counties have limited specialist types, networks may not meet the 90% threshold. Each year, if gaps are identified, the regulators require periodic reporting from insurers to assess the progress made to fill any gaps. Most plans are successful at contracting with providers to close gaps before the networks are active in the upcoming year. For 2025, the below insurers have at least one network that is approved for overall adequacy, but is being monitored for progress on closing one or more provider specific gaps in the below counties:

- PA Health & Wellness – Cambria
- Geisinger – Pike and Potter
- Highmark – Pike
- Oscar – Carbon, Lackawanna, Luzerne, and Monroe
- United HealthCare – Adams, Cameron, Franklin, Indiana, McKean, Pike, and Potter
- UPMC – McKean, Potter, Columbia, Northumberland, and Washington

Consumers are encouraged to contact their health insurance company and/or reach out to PID Consumer Services if they are unable to locate an in-network provider.

Health Insurance Rates

Actuaries review health insurer rates to determine if they are adequate and not excessive. They evaluate the insurer's rate documentation and work with insurers to determine if the evidence justifies the rate requested. The actuaries analyze rate impact drivers such as changes in federal or state law and regulation, claims utilization and credibility assumptions, provider contracting, membership and mix of membership affecting morbidity assumptions, actual to expected risk adjustment and medical loss ratios, calculations of actuarial value to corresponding metal levels, medical advancements, new FDA medication approvals, etc.

Most insurers currently offering individual market coverage in Pennsylvania's 67 counties will continue to provide plans in 2025 with a statewide average increase in rates of 6 percent, which is two percentage points lower than what insurers initially filed. The Commonwealth will see a 7.6 percent average increase in rates the small group market. Rate increases are primarily driven by increases in the cost of health care, which include services and prescription drugs.

Health Insurance Coverage Analysis

Health insurers selling plans in the individual and small group markets submit their health plans and rates to the Office of Product Regulation. When regulators review the submissions, they assess the benefits, coverage, forms, and policies for compliance with state and federal laws. The formularies are reviewed for compliance and to make sure that drug coverage design is not unfairly discriminatory. Mental health benefits are analyzed and compared against the physical health benefits to ensure access, limits, copayments, coinsurance, and coverage procedures are substantially similar.

QHPs are compliant with federal and state laws, but insurers may incorporate additional benefits or features to better serve their members. This report seeks to summarize some of those differences by highlighting a few benefits and how those benefits are generally covered by insurers selling plans in the commonwealth's individual and small group markets. The categories analyzed below include preventive and screening services, mental health, behavioral health, substance use disorder treatments, maternal and reproductive health, telehealth, and weight-loss or anti-obesity treatments.

Note that some of the below medications, services, or benefit types are outside of mandated federal or state requirements. They may not be an essential health benefit, and/or may not be recommended by the United States Preventive Services Task Force (USPSTF). Coverage details are as indicated by insurers selling in the individual and small group Pennsylvania markets.

> ***NOTE: This summary report does not guarantee a benefit or service is covered by your insurer. Each policyholder should contact their insurer or refer to their policy or certificate for full coverage details.***

Category	Medication, Service, or Benefit Type	Coverage Details as Indicated by Insurers (Ind/SG)
Cancer Screenings	Colonoscopy (with biopsy)	All insurers cover colorectal screenings without prior authorization. Some insurers have indicated that cost-sharing may apply for diagnostic colonoscopy testing.
	Prostate Cancer Screening	Eight out of nine insurers cover prostate cancer screening. Insurers that cover this benefit have indicated that prior authorization is not required before receiving services. Some insurers have indicated that cost-sharing may apply.
	Biomarker Testing	All insurers cover BRCA gene mutation screening as required by law. Seven of nine insurers cover biomarker testing generally. Some insurers indicated that prior authorization may be required before receiving services and/or that quantitative limits may apply.
	Multicancer Screening (liquid biopsy) may be utilized for early detection of cancer-derived signals in DNA	Four of nine insurers cover a type of liquid biopsy multicancer screening. Some plans may require prior authorization before receiving services.
	Colorectal cancer screening	All plans cover colorectal cancer screening. All insurers indicated that prior authorization is not required before receiving services.
Vaccinations	Respiratory Syncytial Virus (RSV) Vaccination	All insurers cover RSV vaccinations that follow the CDC schedule without prior authorization or cost-sharing, and some insurers cover vaccinations beyond the CDC schedule, as recommended by a healthcare provider.
Mental Health (MH), Behavioral Health (BH), Substance Use Disorder (SUD)	Mental Health crisis services (may include facility-based crisis, pre/post stabilization, telephonic crisis, walk-in crisis, mobile crisis, crisis in-home support, and crisis residential)	Seven of nine insurers cover mental health crisis services. Some insurers have indicated prior authorization is required or indicated that certain procedure codes may be excluded from coverage.
	Applied behavior analysis (ABA)	All insurers will cover ABA for autism spectrum disorders. Some insurers have indicated that prior authorization is required before starting therapy.
	Peer support services for MH/SUD (a range of activities and interactions between people who share similar experiences with MH and/or SUD)	Three insurers cover peer support services without prior authorization for in-network services. Some insurers indicated that mental health services must be provided by licensed behavioral health providers.
	Neurofeedback therapy, electroencephalogram (EEG) biofeedback for MH disorder feedback	Four insurers cover neurofeedback therapy and most of those insurers do not require prior authorization for in-network services. Some insurers indicated that neurofeedback therapy is considered experimental and/or investigational.
	Intensive Behavioral Health Services (IBHS) support children, youth, and young adults with mental health needs often in homes, schools, and communities	Eight of nine insurers cover IBHS. Some but not all insurers have indicated that prior authorization is required before receiving services.
	Methadone Treatment for opioid use disorder (covered as Medication Assisted Treatment "MAT" required under PA Act 146 of 2022.)	All nine insurers cover methadone as MAT. One insurer covers Methadone as MAT without cost sharing (less HSA eligible plans).

Category	Medication, Service, or Benefit Type	Coverage Details as Indicated by Insurers (Ind/SG)
	Buprenorphine - Considered an important monoline therapy for pregnant people with opioid use disorder.	All insurers cover buprenorphine as MAT, and most cover it on the lowest cost non-preventive drug tier on their formularies. Some but not all insurers have indicated that prior authorization is required before receiving services but may not be required for the buprenorphine tablet specifically.
Maternal & Reproductive Health	Contraception Coverage	All insurers cover at least one form of every FDA-approved contraception method. Some insurers may cover drugs that have no therapeutic equivalents on the market. Insurers' contraception drug formularies vary, covering a minimum of 191 contraception drugs.
	Doula services – Provide emotional, physical, and educational support before, during, and after delivery.	One insurer covers doula service and indicated that prior authorization may be required before receiving services.
	Opill, an Over-the-Counter Oral Contraception Pill	All insurers cover Opill OTC contraception without cost-sharing.
	Surrogacy (prenatal, delivery, and postpartum care) – an arrangement, often supported by a legal agreement, where a gestational carrier carries a pregnancy on someone else's behalf.	Three of nine insurers cover surrogacy services. All three insurers have indicated that prior authorization is not required before receiving services. One insurer limits coverage of the surrogate to situations where they are a covered person under the policy.
	Breast milk storage	Five of nine insurers cover breast milk storage. Some but not all insurers have indicated that prior authorization is required before receiving services. Additionally, one insurer who covers this benefit applies a quantitative limitation of 120 storage bags.
	Supplemental donated human breast milk	Three of nine insurers cover human breast milk. Some but not all insurers have indicated that prior authorization is or may be required before receiving services. Additionally, some insurers have limited this coverage to infants up to six months old. Insurers who cover this benefit may apply different guidelines.
	Zuranolone (first FDA-approved fast-acting oral postpartum depression treatment drug)	Seven of nine insurers cover Zuranolone. Some but not all insurers have indicated that prior authorization is required before receiving services. Additionally, some insurers have indicated that quantity limits may apply. One insurer covers this drug without any limitations or restrictions like prior authorization.
Sexually Transmitted Infection Testing	Coverage of HIV PrEP antiretroviral medication and integral services necessary for PrEP initiation and ongoing follow-up and monitoring. HIV PrEP integral services that will be covered without cost-sharing include: • Encounter for prescribing (up to 90-day supply), adherence and behavioral risk reduction counseling, medication management, and includes Tele-PrEP, i.e., with telehealth Place of Service (POS) codes 02 (telehealth provided other than in patient's home) and 10 (telehealth provided in patient's home).	All insurers cover HIV PrEP drug coverage (both daily oral and long-acting injectable) and integral services. All insurers have indicated that prior authorization is not required for covered HIV PrEP medications and services. All insurers have indicated that cost-sharing is not applicable. Prior authorization may be required for drugs covered through a drug exception process (i.e., drugs that are not otherwise covered under the formulary but where the insurer allows an exception to cover the drug based on the request of the person or their prescribing healthcare provider).

Category	Medication, Service, or Benefit Type	Coverage Details as Indicated by Insurers (Ind/SG)
	• HIV screening test (HIV Ag/Ab plasma test (including home specimen collection kits), rapid point-of-care Ag/Ab blood test, and quantitative or qualitative HIV-1 RNA assay) • Hepatitis B virus screening, testing • Hepatitis C virus screening • Renal function testing (estimated creatinine clearance) • Gonorrhea, chlamydia, and syphilis screening for men and transgender women who have sex with men; Gonorrhea and syphilis screening of pharyngeal, rectal, and urine specimens (3-site testing) using NAAT tests • Gonorrhea and syphilis screening for heterosexually active individuals • Chlamydia screening for heterosexually active individuals • If on 200 mg emtricitabine/25 mg tenofovir alafenamide (F/TAF), triglyceride and cholesterol level monitoring • Pregnancy testing as part of an encounter for HIV preexposure prophylaxis • Encounter for injection, adherence and behavioral risk reduction counseling, medication management (with long-acting injectable PrEP) • HIV screening test (Quantitative or qualitative HIV-1 RNA assay; however, can use rapid point-of-care Ag/Ab blood test for same-day PrEP administration)	
Telehealth	Telehealth/Telemedicine Primary Care or Specialist Services	All insurers cover telehealth/telemedicine primary care and specialist services. All insurers have indicated that prior authorization is not required before receiving services. One insurer covers primary care and specialist telehealth/ telemedicine without cost-sharing (except for HSAs) for unlimited virtual 24/7 care visits received from the plan's designated telehealth providers.
Weight loss / Anti-obesity Medications	GLP-1s or other weight-loss drugs may be prescribed by physicians for the treatment of obesity and weight loss	Obesity and weight loss management drugs (exclusively) are not covered by any insurers. Some insurers have indicated that certain GLP-1s may be available for other health care conditions or for individuals with certain co-morbidities or risk factors.

Health Insurance Exclusions

Insurers include of list of exclusions in each health insurance policy. Exclusions are benefits that are specifically not covered under the policy or include information on specific limitations that may exist for a service or category of services.

Consumers should refer to their health insurance policy to view full exclusion details.

Health Insurance Authority Contacts

The purpose of this report is to give the reader a deeper understanding into how state insurance regulators are reviewing health insurance products. State insurance regulators enforce laws not only as a means to attain a robust and fair market, but also to oversee prompt and equitable treatment of policyholders. Product regulation is one part of the overall regulatory process. Health insurers file their rates, forms, and networks, but they also must provide information regarding their operating procedures, distribution channels, financial characteristics, complaints, and their performance to market and financial regulators at the PID.

The health insurance legal landscape is diverse, nuanced, and may be difficult for consumers to navigate. There is a "no wrong door" philosophy at the PID, so reaching out for questions or to complain is recommended. PID collaborates with other health insurance authority contacts to ensure consumers get the help they need. If you have questions about Medicare, Medical Assistance (HealthChoices, CommunityHealthChoices, or Childrens Health Insurance Plans) or products provided by your employer through a plan that is self-funded, please refer to the below contact information.

Commercial - Pennie or Employer Coverage:
The Pennsylvania Insurance Department
Web: www.insurance.pa.gov
Phone: 1-877-881-6388 or 717-783-3898

Employer Self-Insured Coverage:
The United States Department of Labor
Web: www.dol.gov/EBSA
Phone: 1-866-275-7922

Medicare coverage:
Medicare
Web: www.medicare.gov
Phone: 1-800-MEDICARE

If you have Pennsylvania Medical Assistance (Medicaid):
The Pennsylvania Department of Human Services
Web: www.healthchoicespa.com
Phone: 1-866-550-4355

If you have Children's Health Insurance Program (CHIP) coverage:
Pennsylvania's Children's Health Insurance Program
Web: www.chipcoverspakids.com
Phone: 1-800-986-KIDS (5437)