MILLIMAN REPORT

Analyzing the impact of shifts to level-funded plans

Health insurance market dynamics

Funded by Blue Cross Blue Shield of Louisiana

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Executive Summary

With multiple health plan funding options available to small employers and pressures on employers to offer affordable coverage to employees, it is important to consider the potential market impact of employers shifting between options, particularly towards an increased adoption of level-funded health plans. Small employers that offer health benefits to employees can choose from ACA-compliant fully insured small group health plans, self-funded health plans, and level-funded health plans, each presenting unique costs, product features, and risks. Understanding these differences is essential for anticipating how shifts in plan adoption might influence the overall health insurance market. Blue Cross Blue Shield of Louisiana (BCBSLA) engaged Milliman to study this topic. BCBSLA offers insurance products in the State of Louisiana and has a large share of the market for ACA-compliant fully insured small group health plans in the state. BCBSLA is interested in understanding the impact on the ACA-compliant small group risk pool of level-funded health plans.

LEVEL-FUNDED HEALTH PLANS

Traditionally, employers that offer healthcare coverage to their employees have either purchased a policy from an insurance company, or they have directly paid for healthcare claims as they arise. The latter arrangement is called a self-funded health plan. In recent years, there has been growth in a third type of arrangement called level-funded health plans. These are a hybrid health plan model that combine elements of fully insured financing with elements of self-funding. While employers forego some of the savings potential that exists in a self-funded plan, they do usually retain a portion of that opportunity while also gaining cost predictability through set monthly payments. The carriers that offer these level-funded health plans typically offer the potential for partial refunds to the employer if actual healthcare costs are lower than expected. While small group insurance policies must be priced without regard to an employer group's overall health status, the pricing of a level-funded plan can take health status of the members of the group into account. Because level-funded plans can be priced lower for healthier groups, it is important to consider the impact on the market when employers shift towards that funding mechanism.

Insurance policies are largely regulated by the states, whereas self-funded arrangements are subject to federal regulation that broadly preempts state law. A level-funded plan is, at its core, a self-funded plan. However, employer stop-loss reinsurance, which is regulated by the states, is a necessary component of level-funded plans. Therefore, public policy decisions made by the states regarding the terms and conditions under which employer stop-loss policies are sold can have a significant influence on the availability and attractiveness of level-funded health plans.

IMPACT OF INCREASED ADOPTION OF LEVEL-FUNDED PLANS

There are a number of considerations that come into play with the increased adoption of level-funded health plans by small employers. Key considerations include:

1. **Risk Pool Segmentation:** As healthier small groups migrate to level-funded plans due to potential cost savings, the risk pool for ACA-compliant fully insured plans may deteriorate. This shift could lead to an increase in average claim costs within the fully insured market, thereby driving up premiums for those remaining in that market.
2. **Impact on Insurers:** Insurers offering ACA-compliant plans might update their product portfolios and begin to offer more level-funded options to accommodate the evolving market landscape.
3. **Employer Decision-Making:** Small employers will have more diversified and complex options to manage healthcare costs and risks. This could lead employers to make decisions annually as to whether to choose an ACA-compliant plan or level-funded options based on the health status of the small group and the availability of plans in each market.

The growing adoption of level-funded health plans by small employers could significantly reshape the health insurance market in Louisiana. By attracting healthier groups, these plans may drive changes in the composition of risk pools, market competition, and insurer financial strategies, particularly in the ACA small group market.

Overview of small employer health plan funding options

Health benefits are a major expense for employers, and employers have options for how to provide these benefits to their employees. Understanding the different health plan funding mechanisms available to employers, with a focus on small employers, will help explain the impact of small employers shifting towards level-funding. The three most common funding options for employer-sponsored health insurance are: fully-insured plans, self-funded plans, and level-funded plans.

In certain health plan funding mechanisms (self-funded and level funded arrangements, for example), an employer's cost correlates strongly with the healthcare costs of the employer's own employees and families. In others – in particular, the fully insured small group market – an employer's premium costs are instead related to the healthcare costs of a large pool of employees. The composition of that pool is therefore a key driver of employer costs in that market.

A small employer that provides health benefits to its employees can do so through a variety of funding mechanisms, which have different costs, features, and risks for the employer.

Note that "product type" or "plan type" is sometimes thought of from the end-user perspective. For example, a health plan may be a health maintenance organization (HMO) or exclusive provider organization (EPO) with a small set of covered providers, or it may be a preferred provider organization (PPO)-style plan, with access to a broader set of network providers and non-network providers. Member cost sharing can be at different levels of richness and can be of different types (deductibles, copayments, etc.). In this whitepaper, however, we are referring to the contractual and financial structure of the plan as it relates to the employer and their relationship with the insurance carrier or administrator, along with regulatory considerations. The product types described below can generally be designed with just about any of the consumer-facing features (e.g., provider networks, cost sharing types and levels) mentioned just above, subject to the differing regulatory environment applicable in each case.

> A "product" or "plan" type in this context refers to the contractual and financial funding of the employer's health plan benefits, including regulatory considerations.

ACA-COMPLIANT FULLY INSURED SMALL GROUP HEALTH PLANS

In a fully insured health plan, an employer group pays premiums to an insurer in exchange for the insurer paying claims for healthcare services covered by the policy, subject to the enrollee paying any cost sharing amounts specified in the plan documents. Once premiums are paid, the employer has no financial exposure – favorable or unfavorable – to the actual healthcare costs incurred by the group's covered employees and dependents during the plan year. Because their claim cost experience is pooled with the claim costs of many other employers for purposes of setting future premiums, there is limited financial exposure for the group in the long run.

The Patient Protection and Affordable Care Act (ACA), enacted in 2010 and with many of its major provisions taking effect in 2014, introduced a number of important new features to the small group market. While states maintain their traditional role in regulating the business of insurance within their borders, many aspects of the market are standardized on the federal level.

1. *Single risk pool*: In each state, insurers are instructed to regard all small group enrollees as part of a single risk pool for purposes of setting overall premium levels.
2. *Premium variation limitations*: Premium rates charged to a group may not vary from group to group based on member- or group-level health characteristics. Premiums may only vary based on a group's composition of age, family structure, plan design selection, geographic area, and tobacco use status.
3. *Guaranteed issue*: Insurers are subject to guaranteed-issue and guaranteed-renewability rules. To ensure that insurers can establish premium levels that are available to any group, without regard to health status, a risk

adjustment mechanism provides for transfers of funds from insurers who enroll members of below-average risk to insurers who enroll members of above-average risk.

4. *Metal levels:* The ACA regulates what types of benefit designs can be sold in the small group market. Each plan design must conform to one of four "metal levels," designated as platinum, gold, silver, or bronze. A federally developed tool is generally used to classify plans according to these levels, which generally correspond to the richness of the cost sharing features of the plan. Not all theoretically possible plan designs will meet the definition of any of the four metal tiers.
5. *Essential Health Benefits (EHBs):* The scope of covered benefits must also include the package of essential health benefits (EHBs), defined by each state in accordance with federal guidelines. Insurers are permitted to offer plans that include additional benefits that are not part of the EHB package.
6. *State Law:* Although subject to significant federal rules, ACA-compliant plans must also align with state insurance law where not preempted by federal law and regulation. For example, ACA-compliant plans must provide any benefit design that is mandated by state law, even if not part of the EHB package. Restrictions on cost sharing design enacted at the state level are applicable to small group plans; this could potentially prohibit sale of a particular plan design even if it would be allowed under federal rules. Any revenue from sale of small group ACA-complaint plans is subject to state premium taxation.

In summary, products in the ACA-compliant fully insured small group market:

- Fully transfer financial risk for healthcare costs from employers to the insurer
- Are regulated by both federal and state law, including with respect to imposition of taxes and fees
- Must be designed according to specifications in federal regulations, related to scope of covered benefits and richness of cost sharing features
- Are guaranteed issue, guaranteed renewable, and priced without regard to group- or individual-level health characteristics
- Are covered by a risk adjustment mechanism that aims to remove financial incentives to enroll low-morbidity members

SELF-FUNDED HEALTH PLANS

Claims for a self-funded health plan are not paid for by an insurance company, even though a health insurance company may administer the plan. In this type of arrangement, an employer pays all amounts that are owed under the terms of the plan (i.e., after accounting for any benefit limitations or member cost sharing features). The employer is thus at full risk for the healthcare costs of its covered employees and dependents subject to the terms of the plan, although as described below there are typically features that limit the employer's downside risk.

Administration

Because most employers are in some business other than health plan administration, employers normally contract with a third-party administrator (TPA) to handle tasks such as claim processing, payment disbursement (from employer monies), plan design and legal document development, and provider network building. The administrator may be a health insurer, although in such cases, it is still the employer who is financially liable for the plan's costs. Plan administrators charge a fee for their services that will typically vary based on what administrative services are provided and how many employees or total enrollees are covered by the plan, but not based on the group's actual healthcare costs incurred.

Stop-loss

Many employers with self-funded arrangements will seek to limit their financial exposure to high incurred claim costs. This is often done through stop-loss insurance. For example, a "specific" stop loss policy may cover all claim costs (or a percentage of claims) that a *specific* member incurs above some pre-defined level (the attachment point). If that level is $300,000 and the member has $700,000 in healthcare claims, then the stop-loss insurer would reimburse $400,000 of that member's claim costs to the employer. A group may also have "aggregate" stop-loss insurance that reimburses an employer for its claim payments that exceed a pre-defined level *across all covered members*, also

referred to as the attachment point. To illustrate the difference, two groups might both have $10,000,000 in claim costs. A specific stop-loss policy would tend to provide reimbursement only if a small number of individuals each accounted for a large portion of claims. An aggregate stop-loss policy with an attachment point of $9,000,000 would provide $1,000,000 of reimbursement no matter how the claims were distributed across the members. Employers may have both types of stop-loss coverage simultaneously.

Comparison with fully insured

There are a number of key differences between self-funded health plans and fully insured plans. From a legal and regulatory perspective, a federal law, the Employee Retiree Income Security Act (ERISA), governs self-funded health plans. ERISA broadly preempts state insurance law with respect to self-funded health plans. For example, a self-funded health plan need not comply with state laws that mandate coverage of particular benefits,[1] and states cannot subject self-funded health plans to premium taxation. Employer stop-loss arrangements *are* insurance and are subject to state insurance laws. However, the state laws and regulations that govern stop-loss and ACA coverage are different. For example, ACA rate filings are reviewed by the Department of Insurance, while stop-loss rates are file-and-use in Louisiana. Stop-loss policies are not subject to the ACA features described above that govern small group fully insured health plans. A group's actual projected risk can be taken into account in setting stop-loss premiums without running afoul of federal law. Both for new issue and at renewal, stop-loss carriers evaluate each group's claim history and known medical conditions of the group's members. Groups with members known to have high-cost ongoing medical conditions will tend to face high initial premiums and high rate increases for stop-loss coverage. This is considerably different than an ACA-compliant fully insured health plan, where an employer group's own claim history and health status cannot be used to establish that group's premiums, either at issue or at renewal.

Consider the following example of renewal pricing for three hypothetical groups shown in Figure 1. In this example, suppose that all three groups initially had no members with chronic medical needs when they first obtained coverage two years ago. Since that time, the groups' medical profiles have diverged, either due to new conditions emerging in existing members or due to new employees joining the group.

FIGURE 1: EXAMPLE OF RENEWAL RATE INCREASES

GROUP	COVERED MEMBERS	MEDICAL PROFILE	LIKELY RENEWAL FULLY INSURED PLAN	LIKELY RENEWAL STOP-LOSS COVERAGE
Group 1	20	No significant chronic conditions in the group	8% increase	0% increase
Group 2	20	2 members with Type 2 diabetes	8% increase	15% increase
Group 3	20	3 members with Type 2 diabetes, 2 cancer patients with $150,000 in treatment costs last year	8% increase	50% increase

For fully insured plans, all groups receive the same rate increase, driven by the needed increase for the carrier's entire small group block. Rates cannot vary by group due to a group's health status. For stop-loss coverage, however, group-specific health status and claim history does affect the group's renewal rate. Note that Group 3, which faces a high increase for its stop-loss coverage (as well as high costs for costs paid by the employer below the stop-loss threshold) may have a strong incentive to obtain fully insured coverage to replace its self-funded plan.

Nationally, self-funded plans are much less commonly offered to employees by small employers than by large employers.[2] The larger an employer is, the better able it is to bear the full risk (i.e. no stop-loss coverages) of a self-

[1] Self-funded plans are also not required to offer the EHB package. The ACA's prohibition on annual or lifetime limits does apply, however, to EHBs that are covered in a self-funded plan.

[2] KFF, "2024 Employer Health Benefits Survey," 9 October 2014, Section 10.

funded health plan. This is not simply due to larger employers having greater financial resources than smaller employers, which may or may not be true in every instance. Rather, it is because of the reduced variation in overall claim costs over time. A larger employer with more covered members will have more stable and predictable claim costs over time than a smaller block of covered members. This means that an employer's level of *uncertainty* in its future expenses tends to decline (when measured per member) as its covered population grows. The transfer of risk to an insurer that is a key feature of a fully insured health plan arrangement becomes less valuable to the employer the larger the group is.

For groups that are large enough to be treated as large groups (rather than small groups) under state insurance law, insurers can offer fully insured coverage to an employer with premiums that account for group-specific forecasts of claim costs. Thus, in the long run, both a fully insured plan and a self-funded plan will result in a large employer "paying for its experience" – either directly in the case of a self-funded plan, or through risk-conscious insurance premiums in the case of a fully insured plan. A self-funded arrangement is subject to greater degrees of fluctuation in cost from month-to-month and year-to-year, and a fully insured premium will typically include retention loads that exceed what a self-funded employer would pay.

For groups that are defined as "small group" under state insurance law, the presence of the ACA's risk adjustment mechanism means that in the long run, a group will "pay the experience" of the *entire statewide small group risk pool*. This is because the group's own health characteristics cannot be used to set its premiums. Thus, a self-funded arrangement would tend to be lower cost, in the long run, for groups with healthier-than-average members. However, the risk of high claim costs in any specific month or year is often greater than a small employer is willing to tolerate.

LEVEL-FUNDED HEALTH PLANS

A level-funded health plan is a form of self-funded health plan, as described in the previous section. This type of plan gets its name because it is paired with stop-loss coverage that leaves the employer with a similar risk exposure as it would have in a fully insured arrangement, and because the plan contracts eliminate the month-to-month fluctuations in payments from the employer that often arise in a pure self-funded plan.

The following is a ***hypothetical example*** of how a level-funded plan might work. An employer group could enter into the following agreements with the provider of a level-funded plan:

- A specific stop-loss policy covering all claim costs in excess of $100,000 per member, at a cost of $20 PMPM
- An aggregate stop-loss policy covering total claims (excluding those already paid by the specific stop-loss policy) in excess of $360 PMPM, at a cost of $25 PMPM
- An administrative fee of $30 PMPM
- A commitment by the group with the insurer to pre-fund $360 PMPM for claim costs that are not eligible for reimbursement under either the specific or aggregate stop-loss policies
- A gain-sharing agreement whereby if less than $360 PMPM is ultimately needed for claim costs that are not covered by either stop-loss policy, any such gains are split 50/50 between the employer group and the level-funded plan administrator

The group would thus be committing to pay $435 PMPM ($20 + $25 + $30 + $360). The group **would never have to pay any more than that amount during a 12-month period**, because that payment includes full compensation for administrative services (a $30 fee) and stop-loss policies that transfer the risk for all claim costs above $360 PMPM to an insurer (stop-loss premiums of $20 and $25). There is a possibility that the group could ultimately pay less than $360, however. Suppose that total healthcare costs were $230 PMPM; under the gain-sharing agreement, the group's claims were $130 below the $360 threshold specified above, and so 50% of that difference ($65) would be refunded to the employer group, with the remaining $65 being retained by the level-funded plan provider as an additional contingent fee.

Figure 2 summarizes this example arrangement. It shows both monthly amounts and annualized amounts on the assumption of a group of 50 covered members enrolled for a full year.

FIGURE 2: EXAMPLE OF LEVEL-FUNDED HEALTH PLAN PAYMENTS

PAYMENT TYPE	MONTHLY	ANNUALIZED	IN EXCHANGE FOR PAYMENT, EMPLOYER RECEIVES
Specific stop-loss premium	$20	$12,000	Coverage of all claims that exceed $100,000 per member
Aggregate stop-loss premium	$25	$15,000	Coverage of all claims above $216,000 for the group as a whole
Administrative fee	$30	$18,000	Agreed-upon administrative services (e.g., claim processing, provider network access)
Claims funding advance	$360	$216,000	1. Payment for healthcare services up to $100,000 per member and $216,000 for the group as a whole 2. Partial refund if such costs fall below $216,000 for the year
Total cost	$435	$261,000	

Of the total cost PMPM cost of $435, only $45 is in the form of insurance premiums. Because these are stop-loss premiums rather than fully insured premiums governed by the ACA, the level-funded plan provider can establish the premiums and terms with consideration to an employer group's actual expected claim costs. It may consider information not permitted to be considered in a fully insured small group plan, such as member-level health history (potentially available in historical claims data, third party vendors, or from member-supplied responses to health questionnaires).

Level-funded plan providers typically also cover payments during the year when the need for such payments temporarily exceeds the employer group's cumulative claims funding advances. For example, suppose a group's total annual claims are $200,000 in the example above, and no individual member exceeded $100,000 in costs. For the year in aggregate, the group's $216,000 of claims funding is adequate to cover the $200,000 expense. However, if enough of those claims are incurred early in the year, the group's cumulative advances may temporarily fall below the amount cumulative owed for claims. In a purely self-funded health plan, a group is responsible for making payments whenever they are needed and in whatever amount they are needed. A level-funded plan, as the name implies, allows for the group's payments to be made in level installments throughout the year even if the group's actual healthcare costs follow a different timing pattern.

The net impact of all of these transactions is that the employer has approximately replicated the financial outcome of a fully insured health plan. In reality, however, this has been accomplished through a package of transactions that separate the various functions performed by a fully insured plan issuer (administrative services, acceptance of risk for low-cost claims, acceptance of risk for high-cost claims). The possibility of an experience refund is an additional common feature of level-funded plans that is not available in an ACA-compliant fully insured small group plan.

Note that although the example in Figure 1 above uses a $100,000 specific stop loss level, it is legal in Louisiana for employers to use much lower attachment points. The National Association of Insurance Commissioners (NAIC) publishes a "model act" for regulating employer stop loss coverage; this model requires a minimum specific stop-loss attachment point of $20,000 per individual, and a minimum aggregate attachment point of 120% of expected claims for small groups.[3] While Louisiana has not adopted the exact format of this NAIC model, a related statute exists in Louisiana law.[4] This statute allows for specific stop loss deductibles as low as $10,000. These requirements also apply to self-funded employers who purchase a stop-loss policy. A significant portion of a typical employer group's healthcare costs will relate to individuals with over $10,000 of healthcare costs. Purchasing a specific stop loss policy with a deductible as low as $10,000 may make the risks of self-funding, which are often a barrier to small employers, tolerable to some employers. Of course, the cost of a specific stop-loss policy is much higher at a $10,000 deductible

[3] NAIC, "Stop Loss Insurance Model Act," July 2002, available at https://content.naic.org/sites/default/files/inline-files/MDL-092.pdf.

[4] Louisiana Revised Statutes R.S. 22:883, available at https://legis.la.gov/Legis/Law.aspx?d=507764.

compared to (for example) a $100,000 deductible. But because a group's own risk profile affects the pricing of a stop-loss policy, that cost may or may not be favorable compared to the cost of a fully insured plan. The financial appeal of a level-funded plan to a small employer is also dependent on the availability of aggregate insurance coverage at as low an attachment point as possible, since with a higher attachment point, a group must pre-fund a higher volume of claims.

SUMMARY COMPARISON OF FUNDING TYPES

The following table summarizes key features of small group health plan types.

FIGURE 3: COMPARISON OF HEALTH PLAN TYPES

FEATURE	FULLY INSURED, ACA-COMPLIANT SMALL GROUP	SELF-FUNDED	LEVEL-FUNDED
Claim cost risk	Fully transferred to insurer	Fully retained by employer	Down-side risk transferred to stop-loss carriers, usually potential for experience refund
Monthly plan cost fluctuation	None	Variable	None
Annual plan cost fluctuation	Less variable	More variable	Moderately variable
Stop-loss coverage	Not needed	Available to mitigate risk of high-cost claims, but neither required nor universally used	Essential part of operation of level-funded plans
Premium rate regulation	Regulated by states, following federal law and rules	Not insurance (no premiums to regulate)	Stop-loss components subject to state regulation, costs below stop-loss thresholds are self-funded and are not premium
Other regulation	States are primary regulators, though federal rules are significant	Subject to federal law/regulation, with significant preemption of state law	Core plan is self-funded and thus federally regulated; stop-loss components subject to state law
Premium taxation	May be subject to state premium tax	Not subject to state premium tax	Stop-loss premiums may be subject to state premium tax
Group-specific healthcare risk affects group-specific cost?	No	Yes	Yes

While there are additional considerations besides group size, the number of employees covered under the plan is related to which funding option an employer might select. Typically, smaller employers tend to be fully insured and as the number of employees grows, the funding strategy tends to shift towards level funded, then self-funded (with stop-loss), and finally self-funded (without stop-loss).

Impact of pricing and underwriting on level-funded take-up

As discussed above, plans in the ACA fully insured small group market must be offered to any group without regard to the group's health status.

In a self-funded arrangement, a group directly pays for its own healthcare claims (with employers sometimes, but not always, choosing to purchase stop-loss coverage to transfer some of that risk to an insurer). Given the choice to select between a self-funded arrangement and a fully insured health plan, the self-funded arrangement will tend to be more attractive to groups with lower claim costs. As noted above, smaller groups may be unwilling to accept the risk associated with self-funding or the monthly fluctuation in cash flow demands, because even a group with low *expected* claims will have some years where claims are much higher than expected (and will have many individual months where that happens). Stop-loss coverage, such as is included in a level-funded health plan, can transfer this risk. While that risk transfer is accomplished through payment of a premium, groups with sufficiently low expected claim cost will tend to be the groups for which level-funded health plans cost less than fully insured health plans.[5] Level-funded arrangements also create predictability of the cash flow requirements for an employer.

To the extent that lower-cost groups within the fully insured small group market choose to exit that market the average claim cost of groups that remain would be higher than if those lower-cost groups had remained in the market.

EXAMPLE: BLUE CROSS BLUE SHIELD OF LOUISIANA POPULATION

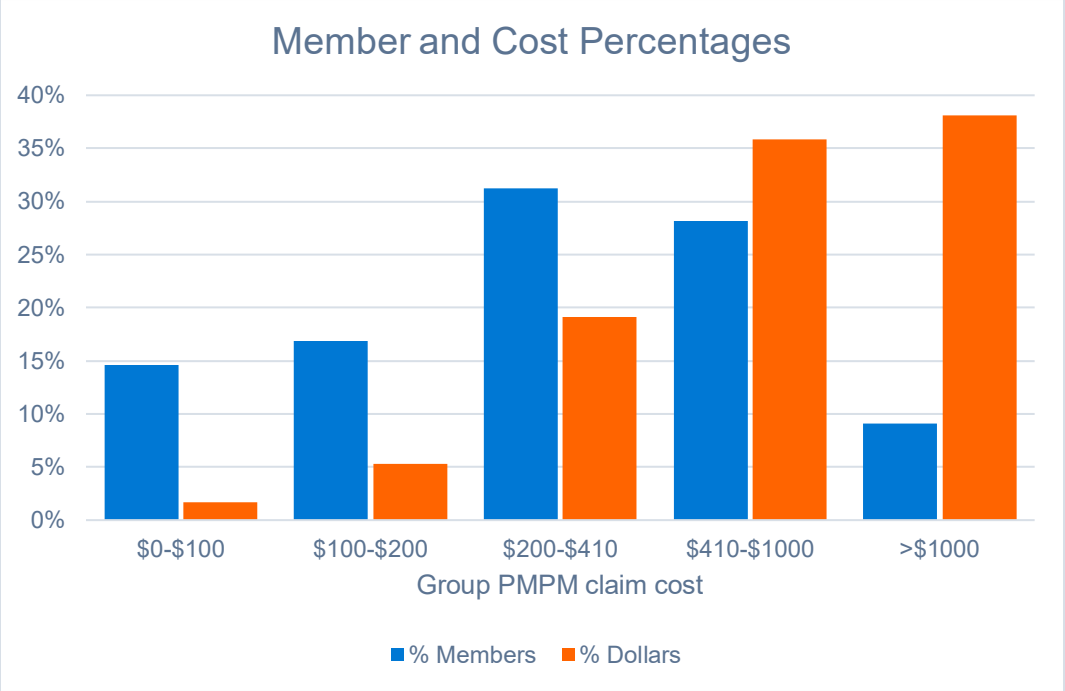
We reviewed data provided by BCBSLA, which is the largest issuer of ACA-compliant small group health insurance policies in Louisiana.[6] The data we reviewed covered experience from 2021 to 2023.

During 2023, BCBSLA's small group block of business had aggregate PMPM claim costs of approximately $485. This average, however, masks the fact that there are groups with both much higher and much lower costs. The following figure shows that a small number of groups account for an out-sized share of total healthcare spending.

[5] Although the ACA-compliant small group market is subject to a risk adjustment mechanism – one of the "premium stabilization" mechanisms included in the ACA – population shifts that affect the market of the state as a whole would still have an impact on premiums. Risk adjustment is at its core a comparison of one insurer's population against the population of the statewide risk pool. If a population shift affects the entire statewide market, however, then premiums of all insurers in the market ultimately must adjust to align with the characteristics of the statewide risk pool.

[6] This paper uses "BCBSLA" to refer, on a consolidated basis, to two legal entities: Louisiana Health Service & Indemnity Company, and HMO Louisiana, Inc.

FIGURE 4: DISTRIBUTION OF SMALL GROUP HEALTHCARE COSTS



Groups with claims costs over $1,000 PMPM were 9% of members but 38% of total healthcare expenditures

Groups with claims under $100 PMPM were 15% of the members but 2% of the healthcare expenditures

Although the average cost across the population was $485 PMPM, only 30% of groups had average costs above that level, with those groups accounting for over two-thirds of the block's total healthcare expenditures. The PMPM costs of the above-average groups was more than double the PMPM cost of the below-average groups.

The overall pattern described above generally holds true for 2021 and 2022 as well. This pattern essentially describes what insurance is. The insured (small employers in this case) exchanges a fixed, known-in-advance premium to transfer responsibility for the uncertain future cost of healthcare. Employers who desire to have their costs align exactly with future healthcare expenses would need to choose a self-funded arrangement to guarantee that outcome.

It is straightforward to estimate the impact of lapses from this block of business by simply removing the claim costs and enrollment for lower-cost groups and then re-calculating the average for the remaining group. For example, if all groups with 2023 claim costs below $100 PMPM are removed from the ACA small group market, the remaining block would be 15% smaller in that year and would have aggregate PMPM claims of $558, which is 15% higher than the original $485. However, this example would only be appropriate if groups knew in advance whether they will be one of the lowest-cost groups in a future time period, and that cannot realistically be known ahead of time.

More realistically, groups with a consistent track record of lower claim costs may seek out alternative funding arrangements such as self-funded or level-funded plans. We compiled information on 2023 claim costs for groups stratified by each group's experience in 2021 and 2022. The following table shows the estimated impact for several scenarios that remove groups from the market based on recent prior costs.

FIGURE 5: EXAMPLE OF SENSITIVITY OF SMALL GROUP BLOCK CLAIM COSTS TO EXITS OF LOW-COST GROUPS

	DESCRIPTION	RESULTING IMPACT	
Example	**Groups moving from market**	**Block size**	**Claim cost**
1	100% of groups with <$100 PMPM	7% smaller	+5% PMPM increase
2	50% of groups with <$100 PMPM	4% smaller	+2% PMPM increase
3	100% of groups with <$174 PMPM	15% smaller	+10% PMPM increase
4	50% of groups with <$200 PMPM	9% smaller	+5% PMPM increase
5	50% of groups with <$410 PMPM	22% smaller	+10% PMPM increase

Summary

Small employers have choices in how they provide health benefits to their employees. A key difference among the funding choices is the extent to which an employer pays costs that relate to its own population's healthcare costs, as opposed to the healthcare costs of a larger block of small employers.

The shift of small employers to level-funded plans can have a significant impact on the small group market. Level-funded plans offer a way for employers to manage healthcare costs by combining features of both fully insured and self-funded plans. As more small groups opt for level-funded plans, the composition of the fully insured pool changes, potentially leading to adverse selection. Healthier groups might gravitate towards level-funded plans to take advantage of potential cost savings, leaving a higher concentration of higher-risk groups in the fully insured market. This could drive up premiums for those remaining in the fully insured pool, increasing the cost burden on higher-cost small employers who do not switch to level-funded options. The overall stability and affordability of the small group market, in part depends on how small groups either migrate or do not migrate towards alternative funding options.

Qualifications, Caveats, and Limitations

QUALIFICATIONS

The authors of this report are consulting actuaries for Milliman, Inc. They are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

CAVEATS AND LIMITATIONS

This report was developed for BCBSLA to provide a description of level-funded health plans, including their general characteristics and potential impact on the fully insured small group risk pool in Louisiana. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty or liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

Actual results (costs, enrollment, and other measures including morbidity and risk pool impacts of migration) will differ from the examples given in this report due to changes in elements that include the characteristics of the enrolled populations, underlying medical costs, regulatory activity, and economic conditions, as well as random fluctuation.

Milliman developed certain models used to estimate the values included in this communication. We reviewed the models, including the data, inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of

practice (ASOP). The results and models, including all inputs, calculations, and outputs may not be appropriate for any other purpose.

The development of estimates in this report relies, in part, on information collected from BCBSLA and other sources that include, but are not limited to, the Centers for Medicare and Medicaid Services (CMS), the NAIC, and S&P Capital IQ Pro. We accepted this information without audit but reviewed the information for general reasonableness. Our projections, results, and conclusions may not be appropriate if this information is not accurate.

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