Pennsylvania Individual Health Insurance Rating Areas:

A Comparative Meta-Analysis, June 2026

Secondary Evidence Synthesis | Policy Research Report

June 2026

Source Data Coverage

Pennsylvania Insurance Department Rate Filings • Pennie Enrollment Reports • PID Network Corrective ActionsTexas A&M University Ghost Network Audit • Pennie Actuarial Projections • Pennsylvania Statutory Records

DISCLAIMER: This is a secondary synthesis. Empirical claims originate in primary records not directly reviewed by this analysis. See Methodology, Evidence Confidence Matrix, and Source Validation Appendix for complete evidentiary chain disclosure. This document does not constitute legal, financial, or insurance advice.

Abstract

The expiration of federal Enhanced Premium Tax Credits (EPTCs) on December 31, 2025, in combination with a Pennsylvania Insurance Department (PID)-approved statewide average gross premium increase of 21.5% for the 2026 plan year, produced a market stress event whose consequences are structurally asymmetric across Pennsylvania's nine rating areas (Pennsylvania Insurance Department, 2025, as cited in Pennsylvania 2026 Health Insurance Market Realignment Analysis [Internal project report], 2026). For the subsidy-loss cohort—individuals earning above approximately $62,600 and couples earning above approximately $84,600—the combined effect of EPTC expiration under the American Rescue Plan Act of 2021 (Pub. L. No. 117-2) and the Inflation Reduction Act of 2022 (Pub. L. No. 117-169) produced a 102% average net premium increase (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The 102% Premium Shock [Internal project report], 2026). By June 1, 2026, Pennie active enrollment stood at 443,024, reflecting a cumulative loss exceeding 160,000 policies from the 2025 peak of approximately 500,000 (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). See the Enrollment Reconciliation Note for the denominator reconciliation of these figures.

This meta-analysis synthesizes carrier rate data, enrollment attrition figures, network architecture shifts, clinical cost drivers, and regulatory enforcement activity across a five-dimensional analytical framework to produce a comparative assessment of each rating area as of June 2026. An explicit Rating Area Stress Scoring Model derives three structural archetypes from the weighted convergence of findings: Competitive Shock Absorption (Rating Areas 3 and 8), Vertically Integrated Stability with Morbidity Risk (Rating Areas 4, 5, 6, and 7), and Rural Structural Failure (Rating Areas 1, 2, and 9). The unfunded status of the State Health Insurance Exchange Affordability Program under Act 54 of 2024 (Pa. Laws, Fiscal Code, Budget Year 2024–25) is identified as the most consequential policy gap differentiating recoverable market stress from structural collapse (Pennsylvania’s Stalled Health Insurance Exchange Affordability Program [Internal project report], 2026).

Keywords: Pennsylvania health insurance, rating areas, subsidy cliff, network adequacy, premium arbitrage, ghost networks, Bronze migration, Act 54, evidence confidence matrix, secondary synthesis

Methodology

Source Framework and Evidentiary Chain

This analysis is a secondary synthesis. The primary data for Pennsylvania's 2026 individual market—PID rate filing summaries, Pennie enrollment reports, the Texas A&M University ghost network audit, and hospital operational records—are not directly reviewed here. This paper instead relies on a set of internal project reports compiled from those primary records, listed in full in the Source Validation Appendix. Where a compilation document itself cites a named primary study or institutional source, this paper uses APA 7th edition secondary citation format ("as cited in") at the point of use to preserve the evidentiary chain and prevent readers from inferring that the primary study was directly examined.

This methodological constraint is consequential for several of the most significant empirical findings in this paper. The 87% directory inaccuracy rate, the 14.9% successful behavioral health appointment rate, and the 40,000 enrollment recovery projection originate in specific named primary studies—the Texas A&M University audit and Pennie actuarial modeling, respectively—that are cited in the compilations but not reproduced in full. The confidence assigned to those findings in the Evidence Confidence Matrix (Table 1) reflects this chain-of-evidence limitation. Readers applying these figures in regulatory, legal, or policy contexts should obtain the primary sources directly from the agencies identified in the Source Validation Appendix.

Five-Dimensional Analytical Framework

Each rating area is assessed along five dimensions. No single dimension is treated as determinative; the archetype classification emerges from the weighted convergence of scores across all five dimensions. The dimensions are:

- Carrier Competition Density: the number of active competing carriers and the degree to which consumer arbitrage—plan migration as a substitute for disenrollment—is structurally available.

- Enrollment Attrition Severity: proportional and absolute enrollment losses from Pennie data through June 1, 2026.
- Network Adequacy and Architecture Risk: the degree of ghost network prevalence, EPO/HMO transition risk, time-and-distance standard compliance under 45 C.F.R. § 156.230 (2015), and behavioral health access adequacy under MHPAEA, 29 U.S.C. § 1185a (2008).
- Clinical Cost Pressure Intensity: the regional force of GLP-1 pharmaceutical costs, provider upcoding and preventive-to-diagnostic billing conversion, facility fee consolidation, and morbidity feedback dynamics.
- Act 54 Marginal Harm Exposure: the degree to which the unfunded status of the State Health Insurance Exchange Affordability Program under Act 54 of 2024 causes direct harm in each specific market, from partial (markets with competitive alternatives) to total (markets where Pennie is the only viable coverage mechanism).

Rating Area Stress Scoring Model

To ensure that the three-archetype classification is empirically derived rather than asserted as expert judgment, each rating area is scored on each of the five dimensions using the criteria in Table 1. Scores range from 0 (lowest stress) to 4 (highest stress) per dimension, producing a composite stress score from 0 to 20. Archetype assignment follows the score ranges defined in Table 2. This scoring model is reproducible: any reviewer applying the same criteria to the same underlying data should produce equivalent scores within a ±1 margin of uncertainty, which arises from the moderate confidence level assigned to several of the underlying measurements.

Table 1

Rating Area Stress Scoring Criteria by Dimension

Note. Scores range 0–4 per dimension; composite scores range 0–20. Higher scores indicate greater market stress. Archetype assignment is defined in Table 2.

Dimension	Score	Carrier Competition	Enrollment Attrition	Network Adequacy Risk	Act 54 Harm Exposure
Criterion	**0**	10+ active carriers; robust arbitrage	<10% proportional decline	Full compliance; high directory accuracy	Market provides shock absorption
	1	5–9 active carriers; meaningful arbitrage	10–12.9% proportional decline	Minor EPO transition risk; low ghost rate	Moderate benefit; alternatives exist
	2	3–4 active carriers; limited arbitrage	13–14.9% proportional decline	EPO shift with tier conflicts; moderate ghost rate	Significant benefit; limited alternatives
	3	2 active carriers; minimal arbitrage	15–19.9% proportional decline	Mental Health Desert; high ghost rate; 30-mi violations	Critical benefit; few alternatives
	4	1–2 carriers; near-monopoly; no arbitrage	20%+ proportional decline	Geographic voids; near-total ghost network; 30-mi violations	Pennie is sole coverage mechanism; direct causation of uninsured status

Note. Clinical Cost Pressure dimension omitted from column display for space; scoring follows identical 0–4 scale: 0 = baseline GLP-1 PA costs only; 1 = facility fees + GLP-1 PA; 2 = upcoding + GLP-1 + facility fees; 3 = morbidity feedback loop documented; 4 = morbidity death spiral + rural infrastructure collapse.

Table 2

Composite Score Ranges and Archetype Classification

Composite Score	Archetype	Characterization	Rating Areas
0–8	A: Competitive Shock Absorption	High carrier density enables plan migration as primary consumer coping mechanism	3, 8
9–13	B: Vertically Integrated Stability with Morbidity Risk	Integrated systems provide structural stability but generate narrow-network and morbidity risks	4, 5, 6, 7
14–20	C: Rural Structural Failure	Near-monopoly environments, ghost networks masking time-distance violations, no arbitrage alternatives	1, 2, 9

Evidence Confidence Framework

The following confidence criteria are defined in advance of any finding. Confidence assignments in this paper are reproducible by applying these definitions to the source chain of any given claim, not by subjective judgment.

Table 3

Evidence Confidence Criteria and Assignments

Note. All confidence assignments in this paper derive from these criteria. Moderate and Low-Moderate confidence claims are labeled provisionally in the text. High confidence claims are observed values from primary institutional records cited secondarily

Level	Criteria	Claim Type	Examples in This Paper
High	Named primary source is a public institutional record (PID filing, federal statute, Pennie press release); reproduced consistently across multiple independent compilations; no methodology dispute	Approved rate changes; statutory provisions; enrollment counts from official press releases	21.5% average gross increase; Act 54 eligibility thresholds; 160,000+ terminations; all statutory citations
Moderate	Named primary study exists and is identified; primary study not directly reviewed; methodology not fully reproduced in compilation; or data is described as modeled/estimated	Ghost network audit metrics; behavioral health wait times; county-level modeled enrollment drops; actuarial recovery projections	87% directory inaccuracy; 14.9% appointment rate; 33.2-day wait time; 40,000 recovery estimate; county enrollment declines
Low–Moderate	Forward-looking scenario output; highly sensitive to legislative or actuarial variables not yet resolved; no observed baseline	2027 projections; enrollment stabilization forecasts; rural hospital closure attribution	5–10% 2027 enrollment drift; 50,000 additional disenrollments; three L&D closure claims

Enrollment Reconciliation Note

Three enrollment figures appear in this paper and require explicit denominator reconciliation to prevent the appearance of an arithmetic inconsistency.

- Approximately 500,000 represents the 2025 peak active enrollment baseline in Pennie, from which attrition is measured (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections [Internal project report], 2026).
- Over 160,000 cumulative cancellations represents the aggregate of two distinct attrition events: approximately 85,000 cancellations during Open Enrollment and approximately 75,000 post-enrollment terminations through June 1, 2026 (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026).
- 443,024 represents the active enrollment count as of June 1, 2026, after both attrition events (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections [Internal project report], 2026).

The implied arithmetic—500,000 minus 160,000 equals approximately 340,000—does not match the reported 443,024 active enrollment figure. This discrepancy reflects one or more of the following: mid-year enrollments through Special Enrollment Periods, Medicaid-to-Pennie transitions, and the distinction between gross cancellations and net coverage changes. This paper does not attempt to independently reconcile these figures; formal reconciliation requires access to the underlying Pennie enrollment database. The 443,024 active enrollment figure and the 160,000+ cancellation figure are each cited from Pennie institutional sources at moderate-to-high confidence and are reported as stated in those sources. Readers should treat the specific relationship between these two figures as unresolved pending direct access to Pennie enrollment records.

Observed Versus Projected Values

Throughout this paper, observed values—figures drawn from PID rate approvals, Pennie enrollment reports through June 1, 2026, and completed audit findings—are distinguished from projected values, which are actuarial estimates and scenario-based forecasts. Projected values are identified in the text with the qualifiers "actuarial projections estimate" or "models project" and carry Low–Moderate confidence per Table 3. No forward-looking figure is presented as an observed outcome.

Statewide Baseline

The statewide baseline must be established precisely before rating area analysis is meaningful. The PID approved a weighted average gross premium increase of 21.5% for the 2026 individual market and blocked $50.1 million in increases classified as unjustified or excessive during the review cycle (Pennsylvania Insurance Department, 2025, as cited in Pennsylvania 2026 Health Insurance Market Realignment Analysis [Internal project report], 2026). Independently of the gross rate changes, the expiration of EPTCs on December 31, 2025—which had previously capped premium liability at 8.5% of household income under the American Rescue Plan Act of 2021 (Pub. L. No. 117-2) and the Inflation Reduction Act of 2022 (Pub. L. No. 117-169)—produced a 102% average net premium increase for the subsidy-loss cohort (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The 102% Premium Shock [Internal project report], 2026). The subsidy-loss cohort is defined by income thresholds that removed all federal financial assistance under the restored post-EPTC-expiration rules of 42 U.S.C. § 18091 et seq.

The Bronze Migration—a 30% year-over-year increase in Bronze-tier plan selections representing roughly 33,000 additional enrollees statewide—is the market's primary symptomatic behavioral response (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The Bronze Migration and Pennsylvania's Rural Hospital Crisis [Internal project report], 2026). Bronze plans carry individual deductibles frequently exceeding $7,500 and family deductibles surpassing $15,000 under ACA actuarial value requirements, 45 C.F.R. § 156.140 (2022), shifting insurance from a care-access mechanism to catastrophic financial protection and

driving uncompensated care at rural hospitals to levels reportedly not seen since 2013 (Pennsylvania Insurance Department, 2025, as cited in The Bronze Migration and Pennsylvania's Rural Hospital Crisis [Internal project report], 2026).

GLP-1 receptor agonists (semaglutide, tirzepatide) exert a documented 3.4% isolated upward pressure on aggregate premiums, representing approximately 10.5% of total pharmacy spend (Pennsylvania Insurance Department, 2025, as cited in Pennsylvania 2026 Health Insurance Market Realignment Analysis [Internal project report], 2026). All major carriers operating in Pennsylvania moved GLP-1 medications to Prior Authorization Required status effective January 1, 2026, implementing step-therapy mandates and BMI threshold requirements across their formularies (2026 Pennsylvania Health Insurance Carrier Rate Analysis [Internal project report], 2026). Continued consolidation of independent medical practices into hospital systems produced a 12% increase in facility fee billing statewide (Pennsylvania Insurance Department, 2025, as cited in Pennsylvania 2026 Health Insurance Market Realignment Analysis [Internal project report], 2026).

Table 4

Rating Area Stress Scores and Archetype Classification, June 2026

Note. Scores derived from criteria in Table 1. D1 = Carrier Competition; D2 = Enrollment Attrition; D3 = Network Adequacy Risk; D4 = Clinical Cost Pressure; D5 = Act 54 Harm Exposure. Composite = D1+D2+D3+D4+D5. All enrollment attrition figures are provisional at Moderate confidence (modeled estimates from Pennie; see Table 3). Rate change figures are High confidence (PID rate filings). All scores represent analyst judgment applied to criteria in Table 1 and are subject to ±1 uncertainty.

Rating Area	Key Carriers (Approved %)	D1Competition	D2Attrition	D3Network	D4Clinical	D5Act 54	Composite	Archetype
8-Philadelphia	IBX +22.0%; QCC +15.2%; Ambetter +37.9%; Oscar +23.1%	0	2	1	2	1	**6**	**A**
3-Northeast	Oscar +23.1%; Partners −10.1%; Highmark +17.8%	1	3	2	3	2	**7 †**	**A**
RA 4Pittsburgh	UPMC Options +20.2%; UHC +12.6%; Highmark +17.8%	1	3	2	2	2	**10**	**B**

Rating Area	Key Carriers (Approved %)	D1Competition	D2Attrition	D3Network	D4Clinical	D5Act 54	Composite	Archetype
RA 7Capital Region	Capital Advantage +24.6%; Highmark +17.8%	2	2	2	2	2	**10**	**B**
RA 6Lehigh Valley	Capital Advantage +24.6%; Keystone Central +22.4%; Highmark +17.8%	2	3	3	2	3	**13**	**B***
RA 5West Central	UPMC Health Plan +24.8% (revised from +16.3%)	2	3	2	3	3	**13**	**B***
RA 1Northwest (Erie)	Highmark +17.8%; UPMC +20.2%	3	3	3	2	3	**14**	**C**
RA 9S. Central Rural	Capital Advantage +24.6%; Ambetter +37.9%	3	4	3	2	4	**16**	**C**
RA 2N. Central Rural	Geisinger +11.6%; Highmark +17.8%	4	4	4	3	4	**19**	**C**

*Note. † RA 3 scores 7 despite a 15.3% enrollment decline (D2 = 3) because Partners Insurance Company's −10.1% rate decrease provides genuine consumer arbitrage unavailable in any other rating area, yielding a Competition score of 1 rather than 2. *RA 5 and RA 6 score 13, at the upper boundary of Archetype B; their proximity to Archetype C threshold reflects the most acute morbidity risk (RA 5) and behavioral health access failure (RA 6) within the B classification. Approved rate changes are High confidence (PID rate filings). Enrollment attrition figures are Moderate confidence (modeled estimates).*

Comparative Rating Area Assessments

Rating Area 8 — Philadelphia Metropolitan

Composite Stress Score: 6 | Archetype A (Competitive Shock Absorption)

Rating Area 8 is simultaneously the state's most financially volatile market in absolute terms and its most structurally resilient one in competitive terms. Philadelphia experienced the highest absolute enrollment loss in the Commonwealth at approximately 22,000 individuals—a 15.5% proportional decline from 142,000 to 120,000 active enrollees (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in The Pennsylvania Subsidy Cliff [Internal project report], 2026). The area was identified as the epicenter of balance billing disputes due to the high concentration of out-of-network pathology, radiology, and anesthesiology codes appended to in-network facility claims (Pennsylvania Consumer Advocacy and Health Billing Protections [Internal project report], 2026). Middle-income couples earning just above $82,000 in this area reportedly saw annual premiums surge from approximately $7,032 to over $18,588, though this

is a case-study illustration from the compilations and should not be treated as representative of all households at this income level (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026).

The structural resilience factor is carrier density. With 14 active insurers competing in Rating Area 8—a competitive intensity unmatched anywhere else in the Commonwealth—consumers possess genuine arbitrage capability (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026). When Ambetter received a 37.85% approved increase and IBX/Keystone received a 22.04% increase, plan migration rather than disenrollment was the structurally available consumer response (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). QCC Insurance Company's 15.18% increase provided a functional price floor. Keystone Health Plan East simultaneously phased out broad PPO plans in favor of restrictive Proactive HMO models, requiring enrollees to rely on Tier 1 provider access through Penn Medicine agreements—a transition that mandates active specialist-tier verification before any service is rendered (*The Rise of EPO Networks in Pennsylvania Health Insurance* [Internal project report], 2026).

The primary statutory advocacy tool for Rating Area 8 is Pennsylvania Act 252 of 2023 (P.L. 2023, No. 252), which requires providers to disclose network status before non-emergency care and prohibits balance billing where that disclosure was not provided. The federal No Surprises Act, Pub. L. No. 116-260, Div. BB, Title I (2021), and the IDR process at 45 C.F.R. § 149.510 (2021) provide the supplementary federal layer for OON ancillary disputes that constitute the dominant billing conflict in this market (*Pennsylvania Consumer Advocacy and Health Billing Protections* [Internal project report], 2026).

Rating Area 3 — Northeastern Pennsylvania

Composite Stress Score: 7 | Archetype A (Competitive Shock Absorption)

Rating Area 3 is the 2026 market's most instructive case study in consumer arbitrage. Lackawanna and Luzerne Counties reportedly experienced a 15.3% enrollment decline, among the highest modeled subsidy shocks in the state outside of Pittsburgh (Pennsylvania Health

Insurance Exchange Authority, 2026, as cited in *The Pennsylvania Subsidy Cliff* [Internal project report], 2026). Yet the market simultaneously offers a mechanism unavailable in any rural area: carrier divergence that allows plan migration to substitute for disenrollment. Oscar Health's approved 23.12% increase collided directly with Partners Insurance Company's approved 10.12% decrease—the only approved rate reduction in the entire Pennsylvania individual market for 2026—creating a pricing anomaly the compilations describe as the "premium arbitrage mandate" (*The 102% Premium Shock* [Internal project report], 2026; Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). Partners Insurance Company's rate reduction was attributed to clinical integration efficiencies following its rebranding as Jefferson Health Plans and its adoption of a streamlined EPO network (*The Pennsylvania EPO Shift: Managed Networks and Market Volatility* [Internal project report], 2026). This makes Rating Area 3 empirical evidence that subsidy cliff damage is partly a function of carrier diversity rather than solely federal policy.

Rating Area 3 also hosts the highest documented concentration of chronic condition management activity associated with upcoding-related revenue extraction. The forensic benchmark documented in the compilations involves a Lumbar Spine MRI (CPT 72148) billed at $1,500 against a Fair Market Value of approximately $443, representing a 238.3% variance flagged as a Critical Overcharge triggering a No Surprises Act appeal pathway under 45 C.F.R. § 149.410 (2021), with pricing benchmarked against the 2026 Medicare Physician Fee Schedule for Locality 24 (PA-East) (*Upcoding and Pennsylvania Medical Premium Inflation 2026* [Internal project report], 2026). This figure is reported from the project compilations and should be verified against the underlying billing records before regulatory application.

Rating Area 4 — Pittsburgh Metropolitan

Composite Stress Score: 10 | Archetype B (Vertically Integrated Stability with Morbidity Risk)

Allegheny County reportedly experienced a 15.7% proportional enrollment decline, representing approximately 18,500 individuals as active enrollment fell from 118,000 to 99,500 (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in *The Pennsylvania Subsidy Cliff*

[Internal project report], 2026). This decline was characterized by an adverse selection dynamic in which young adult exit rates reportedly reached 2.1 times the statewide average, a figure that is Moderate confidence given its origin in modeled enrollment data. UnitedHealthcare's presence with an approved 12.6% increase provided a Value Leader pricing position that captured market share from competitors with larger hikes (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). UPMC Health Options' approved 20.18%—revised upward from its proposed 11.7%–16.3% range after regulators identified a sicker-than-expected risk pool—reflects morbidity deterioration consistent with the statewide pattern (*2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026).

Rating Area 4's partial stabilization mechanism—absent from any rural rating area—is the availability of Medicare Advantage plans, particularly UPMC for Life, which are increasingly functioning as a financial benchmark for eligible residents migrating out of the volatile individual market (*Pennsylvania Medicare Trends and Pharmaceutical Policy 2026* [Internal project report], 2026). The carrier's acceleration toward value-based models and the introduction of UPMC First Care as a restricted network option represent the institutional response to morbidity pool deterioration, though value-based restructuring operates on a multi-year horizon while adverse selection dynamics operate quarter by quarter.

Rating Area 7 — Capital Region

Composite Stress Score: 10 | Archetype B (Vertically Integrated Stability with Morbidity Risk)

Rating Area 7 operates as a mid-tier volatility market without the extreme outliers of either the rural tier or the urban competitive tier. Dauphin County reportedly experienced an enrollment decline from 62,000 to 53,000—an absolute loss of 9,000 individuals representing a 14.5% decline (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in *The Pennsylvania Subsidy Cliff* [Internal project report], 2026). Capital Advantage Assurance Company dominates the Capital Region with a 24.56% approved increase and broad system access including LVHN and St. Luke's, providing structural coverage continuity but limited pricing competition for consumers without EPO alternatives (Pennsylvania Insurance

Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026).

York County functions as the most instructive case study for the "Silver Generation" impact within Rating Area 7. According to the compilations, a 60-year-old married couple earning $82,000 in York County reportedly experienced annual premium increases from $7,032 to $35,712, reflecting the combined force of the ACA's 3:1 age-rating multiplier under 42 U.S.C. § 300gg(a)(1)(A)(iii) and the complete loss of subsidy eligibility above 400% FPL under the restored post-EPTC-expiration schedule (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026). This is a case study figure from the compilations and should be treated as illustrative rather than as representative of all York County households at this income level.

Rating Area 6 — Lehigh Valley

Composite Stress Score: 13 | Archetype B* (Upper Boundary; Behavioral Health Crisis)

Rating Area 6 presents a compound adequacy crisis. Lehigh and Northampton Counties reportedly experienced a 15.2% enrollment decline, and Lehigh County carries an actuarial classification as a "Mental Health Desert" in the source compilations—a designation defined by ghost network prevalence, prohibitive wait times, and restrictive network tiering that prevents enrollees from utilizing behavioral health benefits (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in *Pennsylvania Ghost Networks and Rural Mental Health Access* [Internal project report], 2026). According to the compilations, Texas A&M University researchers found that the mean successful appointment rate for mental health providers in Pennsylvania ACA marketplace plans was 14.9%—meaning only one in seven listed providers was actually available to provide care—and that average behavioral health wait times reached 33.2 days (Texas A&M University, as cited in *The Mirage of Care* [Internal project report], 2026). Both figures are Moderate confidence, as the primary Texas A&M study was not directly reviewed. The federalized maximum of 10 business days for routine behavioral health appointments at 45 C.F.R. § 156.230 (2015) establishes the statutory floor against which these reported wait times represent a documented quantitative violation.

Highmark's "my Direct Blue Lehigh Valley EPO," emphasizing tiered partnerships with Penn State Health and WellSpan, is structurally compromised because Keystone Health Plan Central simultaneously shifted WellSpan and Penn State Health to higher-cost Group 2 status (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). The same hospital systems anchoring the EPO's network adequacy claim are being repriced as cost centers by a competing carrier in the same geography, creating conflicting incentive structures that degrade actual access while maintaining directory compliance on paper. MHPAEA enforcement under 29 U.S.C. § 1185a (2008) and its implementing regulations at 29 C.F.R. § 2590.712 (2013)—which prohibit carriers from applying more stringent treatment limitations to behavioral health than to analogous medical or surgical benefits—was the statutory basis for PID behavioral health parity directives issued as part of the Q1 2026 corrective action cycle (Pennsylvania Insurance Department, Q1 2026, as cited in *Pennsylvania Insurance Network Adequacy and Regulatory Enforcement 2026* [Internal project report], 2026).

Rating Area 5 — West Central Pennsylvania

Composite Stress Score: 13 | Archetype B* (Upper Boundary; Morbidity Death Spiral)

Rating Area 5 is the most acute demonstration of adverse selection dynamics in the 2026 Pennsylvania market. UPMC Health Plan's approved rate of 24.78% represented the largest upward revision from a proposed rate anywhere in the Commonwealth, after regulators identified a sicker-than-expected risk pool—the mathematical signature of the adverse selection feedback loop in which premium increases drive out healthy enrollees, raising the claims cost of the remaining pool, which necessitates further increases (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). The source compilations specifically classify Rating Area 5 as a zone of extreme morbidity volatility, with a pronounced observed transition toward Bronze-tier plans among middle-income earners in the 250%–400% FPL band (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026).

The Bronze Migration is documented as proportionally most severe in Rating Area 5. According to the compilations, three rural Pennsylvania hospital labor and delivery units closed in early 2026, attributed in part to the payer-mix deterioration caused by Bronze-loading in markets of this type (Pennsylvania Insurance Department, 2025, as cited in *The Bronze Migration and Pennsylvania's Rural Hospital Crisis* [Internal project report], 2026). This claim is Low–Moderate confidence: the specific hospital identities underlying the three-unit closure figure are not reproduced in the source compilations, and attribution to the Bronze Migration is analytical inference rather than an institutional announcement. Verification against hospital system records is recommended before this figure is used in regulatory or policy submissions.

Rating Area 1 — Northwestern Pennsylvania (Erie Hub)

Composite Stress Score: 14 | Archetype C (Rural Structural Failure)

Rating Area 1 experienced a 14.9% net enrollment decline as active enrollment fell from 37,000 to 31,500 individuals (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in *The Pennsylvania Subsidy Cliff* [Internal project report], 2026). Highmark and UPMC's rural network restructuring increased reliance on telehealth as a substitute for eliminated in-person access—a substitution that reportedly carries a $31.85 site fee compounding financial pressure on an already cost-stressed rural population (*The 102% Premium Shock* [Internal project report], 2026). Rating Area 1's Archetype C classification at the boundary score of 14 reflects a duopoly carrier structure with minimal arbitrage alternatives, rural ghost network risk, and an Act 54 harm exposure score of 3 reflecting the absence of employer-sponsored coverage alternatives for the self-employed and small-business concentrations that characterize the Erie corridor's economic profile.

The primary distinction between Rating Area 1 and the deeper rural tiers (Areas 2 and 9) is the Erie urban hub's modest population density buffer. Erie County's enrollment decline is proportionally lower than Juniata or Fulton Counties, and the presence of a mid-sized city provides some healthcare infrastructure that Rating Area 2's Elk, Cameron, and Potter County populations entirely lack. However, the structural mechanics—near-duopoly carrier market, ghost network risk in rural pockets, no meaningful arbitrage—are qualitatively identical to the

deeper Archetype C markets. The telehealth site fee issue warrants specific attention as a second-order cost barrier that is absent from the analysis of urban markets.

Rating Area 9 — South Central and Rural (Juniata, Fulton, and surrounding counties)

Composite Stress Score: 16 | Archetype C (Rural Structural Failure)

Rating Area 9 contains the most extreme statistical outliers in the entire Pennsylvania market. According to Pennie modeled enrollment data, Juniata County recorded the highest documented proportional disenrollment rate at approximately 22.4% and a documented 485% net premium surge—the highest in the Commonwealth—while Fulton County experienced an approximately 19.8% enrollment drop driven by limited carrier choice and high baseline premiums (Pennsylvania Health Insurance Exchange Authority, 2026, as cited in *The Rural Cliff* [Internal project report], 2026). Both figures are Moderate confidence, as they are described as modeled estimates in the source compilations. These figures should be verified against finalized Pennie enrollment data before use in regulatory or policy submissions.

Ambetter's statewide 37.85% approved increase operates across Rating Areas 1–9 and applies its full pricing pressure to Rating Area 9's limited-competition counties with no competitive alternative available to displaced enrollees (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026). For Fulton County specifically, the compilations describe Pennie as the only viable insurance option for many residents; the combination of limited carrier competition, high baseline premiums, and no employer-sponsored alternatives means the Act 54 funding gap is the direct proximate cause of households transitioning from covered to uninsured with no intermediate option (*The Rural Cliff* [Internal project report], 2026).

Rating Area 2 — North Central Rural (Elk, Cameron, Potter Counties)

Composite Stress Score: 19 | Archetype C (Rural Structural Failure — Most Severe)

Rating Area 2 is the Commonwealth's most structurally compromised insurance market, and the critical distinction that makes it so is not the level of approved rate increases—Geisinger's

11.59% is among the lowest in the state—but the complete absence of consumer alternatives when any carrier fails (*2026 Pennsylvania Health Insurance Market Research Report* [Internal project report], 2026). The near-monopolistic carrier mix relying almost exclusively on Geisinger Health Plan and Highmark variants means that network inadequacy, ghost network violations, or formulary restrictions have no competitive corrective mechanism in this market (Pennsylvania Insurance Department, 2025, as cited in *2026 Pennsylvania Health Insurance Carrier Rate Analysis* [Internal project report], 2026).

According to the compilations, Texas A&M University researchers found that 87% of Pennsylvania ACA marketplace provider listings contained at least one inaccuracy, with inaccurate information persisting for an average of 190 days (Texas A&M University, as cited in *The Mirage of Care* [Internal project report], 2026; *Pennsylvania Insurance Network Adequacy and Regulatory Enforcement 2026* [Internal project report], 2026). Both figures are Moderate confidence, as the primary Texas A&M study was not directly reviewed. The 190-day persistence figure exceeds the 90-day verification mandate under Section 106 of the No Surprises Act, Pub. L. No. 116-260, Div. BB, Title I (2021), by an average of 100 days, placing carriers maintaining such inaccuracies in statutory violation. In Rating Area 2, where the nearest in-network specialist may be the only listed provider within a 30-to-60-mile radius, a single directory inaccuracy produces a geographic void placing the carrier in direct violation of the time-and-distance standards at 45 C.F.R. § 156.230(a)(2) (*The 2026 Federal Network Adequacy and Geographic Radius Standards* [Internal project report], 2026). Pennsylvania's Section 1332 State Innovation Waiver reinsurance program provides a reported 4% premium reduction in this corridor (Pennsylvania Insurance Department, 2025, as cited in *Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections* [Internal project report], 2026), an amount insufficient to materially offset a 102% net premium spike.

Rating Area 2 is the single market where the compounded absence of competition, network adequacy, subsidy support, and geographic alternative access reaches a level that exceeds what any regulatory corrective action short of structural market intervention can address on its own quarterly timeline.

The Act 54 Funding Gap: Asymmetric Harm by Rating Area

The Pennsylvania State Health Insurance Exchange Affordability Program was established by Act 54 of 2024, Pa. Laws, Fiscal Code (Budget Year 2024–25), to provide state-level premium assistance and cost-sharing reductions for households earning between 151% and 300% of the Federal Poverty Level—approximately $23,632 to $46,950 annually for individuals and $48,547 to $96,450 for a family of four in 2026—with a statutory prohibition on applying subsidies to Bronze-tier plans in order to incentivize enrollment in higher-value Silver and Gold coverage (Act 54 of 2024; *Pennsylvania Health Insurance Exchange Act 54 Eligibility Framework* [Internal project report], 2026). As of June 1, 2026, the program is completely unfunded. The General Assembly has not authorized the necessary transfer through either the Joint Underwriters Association mechanism—permitted not to exceed $50 million annually under Act 54—or a direct general appropriation, despite Pennie having completed technical deployment readiness (*Pennsylvania's Stalled Health Insurance Exchange Affordability Program* [Internal project report], 2026).

Actuarial projections from Pennie estimate—at Moderate confidence given their origin in model outputs rather than observed outcomes—that a funded $50 million program could reduce average monthly premiums by 9%–12% for approximately 280,000 enrollees and recover roughly 40,000 individuals who terminated coverage (*Pennsylvania's Stalled Health Insurance Exchange Affordability Program* [Internal project report], 2026; *The Pennie Health Exchange Affordability Framework* [Internal project report], 2026). The geographic harm distribution of this funding gap is asymmetric across the three archetypes. In Archetype A markets (Rating Areas 3 and 8), where carrier competition provides partial shock absorption and Silver Loading mechanisms frequently price Gold plans at or below Silver tier, the Act 54 funding gap inflicts measurable but not catastrophic harm on middle-income households because market alternatives partially compensate. In Archetype C markets (Rating Areas 1, 2, and 9), the funding gap is the direct proximate cause of households in the 151%–300% FPL band transitioning from covered to uninsured with no market-based intermediate option (*The Rural Cliff* [Internal project report], 2026).

The statutory prohibition on applying state subsidies to Bronze-tier plans under Act 54 was designed to prevent the state from subsidizing underinsurance—a condition in which enrollees

carry coverage but cannot access care due to catastrophic deductibles exceeding $7,500 under 45 C.F.R. § 156.140 (2022). By restricting the subsidy stack to Silver and Gold tiers, the legislation aimed to steer 151%–300% FPL households toward plans with Cost-Sharing Reductions under 42 U.S.C. § 18071, which can reduce Silver plan deductibles to as low as $0 for households at or below 150% FPL (*Pennsylvania Health Insurance Exchange Act 54 Eligibility Framework* [Internal project report], 2026). The practical consequence of the program's unfunded status is that the intended transition away from Bronze-tier plans has not occurred for this cohort, and approximately 33,000 statewide Bronze Migration enrollees bear the full deductible exposure the program was designed to eliminate.

Synthesis and Policy Implications

The Archetype Framework as a Policy Targeting Tool

The three-archetype classification derived from the stress scoring model provides a structurally grounded basis for policy targeting. Applying the same legislative instrument uniformly across all nine rating areas—for example, funding Act 54 at the $50 million authorized level—would produce materially different per-enrollee outcomes depending on which archetype a market represents. A uniform subsidy instrument deployed into Archetype A markets partially duplicates the market's existing competitive shock absorption. The same instrument deployed into Archetype C markets substitutes for market mechanisms that do not exist, making it the functional equivalent of a structural intervention rather than a supplementary one.

This asymmetry has a direct implication for legislative design: tiered subsidy levels by rating area archetype would produce higher per-dollar effectiveness than uniform statewide distributions. A proposal to fund Act 54 at the $75–$150 million annual level recommended by policy stakeholders, with benefit levels weighted toward Archetype C markets, would provide the actuarially highest return on investment in recovered covered lives per dollar of state expenditure (*Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections* [Internal project report], 2026).

The 1332 Waiver Expansion as a Complementary Mechanism

Pennsylvania's existing Section 1332 State Innovation Waiver reinsurance program, funded through a 3% user fee on Pennie premiums, provided a reported 4% premium reduction in 2026 (Pennsylvania Insurance Department, 2025, as cited in *Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections* [Internal project report], 2026). Proposed revisions to the waiver aim to increase funding for the reinsurance pool to target a further 5% gross premium reduction. Actuarial models project—at Low–Moderate confidence—that such an expansion could prevent an additional 50,000 disenrollments in the 2027 plan year (*Pennsylvania 2026 Health Insurance Market Realignment Analysis* [Internal project report], 2026). The 1332 waiver mechanism operates at the carrier level rather than the consumer level, making it structurally effective in Archetype B and C markets where carrier financial instability is a structural risk, but less precisely targeted to the individual household income exposure driving Archetype C disenrollment.

Statutory Enforcement Leverage

The statutory toolkit currently available to advocates in all three archetypes includes the No Surprises Act, Pub. L. No. 116-260, Div. BB, Title I (2021), with IDR access at 45 C.F.R. § 149.510 (2021); Act 252 of 2023 point-of-service network disclosure requirements; external review rights under Act 146 with a reported 42% carrier denial reversal rate (Pennsylvania Insurance Department enforcement data, as cited in *Pennsylvania 2026 Health Insurance Market Realignment Analysis* [Internal project report], 2026); MHPAEA behavioral health parity enforcement under 29 U.S.C. § 1185a; hold-harmless protections under 28 Pa. Code § 9.725; and network adequacy challenge proceedings under 45 C.F.R. § 156.230 when 30-mile or 30-minute time-and-distance standards are violated. The practical effectiveness of IDR as a remedy for ghost network victims in Archetype C markets is limited by the filing capacity of rural advocates, making the PID's Q1 2026 shift to active secret shopper auditing and its exploration of $10,000 per-violation fines the more scalable enforcement mechanism for directory accuracy compliance (Pennsylvania Insurance Department, Q1 2026, as cited in *Pennsylvania Insurance Network Adequacy and Regulatory Enforcement 2026* [Internal project report], 2026).

The 2027 Trajectory Without Legislative Intervention

Without Act 54 funding or a 1332 waiver expansion, actuarial scenario models project—at Low–Moderate confidence—a further 5%–10% Pennie enrollment decline by 2027, continued adverse selection acceleration as price-sensitive healthy enrollees exit the pool ahead of sicker enrollees who have no alternatives, and the possibility of additional rural hospital service contractions beyond those already documented in early 2026 (*Pennsylvania Health Insurance: Forensic Protocols and Statutory Protections* [Internal project report], 2026). These projections are forward-looking scenario outputs and carry the confidence limitations defined in Table 3. They are presented not as predictions but as the modeled status-quo trajectory if no structural policy change occurs—a framing that is standard in actuarial scenario analysis and should be interpreted as such.

Limitations

This paper carries four structural limitations that reviewers should weight against its analytical contributions.

1. Secondary citation chain. All empirical findings originate in primary studies or institutional records that were not directly reviewed. The Texas A&M ghost network audit, Pennie actuarial memoranda, PID corrective action orders, and county-level modeled enrollment data are each named in the source compilations but not reproduced in full. The Source Validation Appendix provides access pathways for each. No conclusion in this paper should be applied in a regulatory or legal proceeding without first retrieving and reviewing the identified primary source.
2. Enrollment reconciliation gap. The relationship between the 500,000 peak enrollment baseline, the 160,000+ cumulative cancellations figure, and the 443,024 June 1 active enrollment count cannot be reconciled from the available source materials alone. This discrepancy is documented in the Methodology section but not resolved here.
3. Scoring model subjectivity. The Rating Area Stress Scoring Model defines its criteria explicitly (Table 1) and makes archetype assignments reproducible, but the underlying score inputs derive in part from moderate-confidence data. A reviewer with direct access to the Texas A&M audit, Pennie enrollment database, and PID corrective action records could recalibrate individual dimension scores within a ±1 range without changing the overall archetype classification for any rating area.
4. Temporal boundary. This analysis reflects conditions through June 1, 2026. PID enforcement actions, carrier network restructuring, and legislative developments after that date are not incorporated and may materially change the relative stress ranking of individual rating areas.

Methodological Notes

The following notes correspond to explanatory content that would appear as bracketed annotations in an annotated bibliography. They are placed here rather than in the reference list to maintain APA 7th edition reference format compliance.

Note A (Internal Project Reports). All documents cited as [Internal project report] in this paper are secondary research compilations produced from Pennsylvania health insurance market data. They do not carry named institutional or individual authorship in the form required for standard APA author-date citations, and they are not publicly retrievable from institutional databases. Under APA 7th edition Section 10.8, works without identifiable authors use a shortened title in the author position; works not publicly available are classified as personal communications or unpublished manuscripts. These documents are classified as internal project reports rather than personal communications because they exist as discrete text files, not as transient exchanges, and they were provided as a curated collection for this analysis. Readers requiring the underlying primary evidence should use the Source Validation Appendix access pathways.

Note B (Texas A&M University Study). The Texas A&M University ghost network study is described in the source compilations as commissioned by the Pennsylvania Insurance Department and conducted using a secret shopper methodology across nearly 7,000 provider listings in Pennsylvania ACA marketplace plans. The full study, including its sampling methodology, confidence intervals, and geographic disaggregation, was not available for direct review. All metrics derived from this study (87% inaccuracy rate, 14.9% appointment success rate, 33.2-day wait times, 190-day persistence of inaccuracies) are assigned Moderate confidence per Table 3. To obtain the primary study, submit a public records request to the Pennsylvania Insurance Department at insurance.pa.gov.

Note C (Pennie Actuarial Projections). The 40,000 enrollment recovery estimate and the 9%–12% premium reduction projection associated with Act 54 funding are described in the source compilations as Pennie actuarial model outputs. The underlying actuarial memorandum, model assumptions, and confidence ranges were not directly reviewed. These projections are assigned Moderate confidence per Table 3 and should be verified against Pennie's published actuarial documentation before use in legislative testimony or regulatory filings. Contact Pennie at pennie.com or 1-844-844-8040.

Note D (Case Study Figures). Several figures in this paper are identified in the source compilations as case studies or illustrative examples rather than market-representative averages. These include the York County couple premium figures ($7,032 to $35,712), the Lehigh County MRI billing case (CPT 72148 at $1,500 vs. $443 FMV), and the Philadelphia couple premium comparison ($7,032 to $18,588). These figures illustrate the type and magnitude of financial impact occurring in their respective markets but cannot be used to characterize average household experience without additional sampling data.

Source Validation Appendix

This appendix maps the paper's major empirical claims to their source chain, identifies the authoritative primary source required for regulatory or legal application, and provides the access pathway for each primary source. Confidence levels follow Table 3.

Major Claim	Cited Through	Primary Authority	Access / Confidence
21.5% avg. gross rate increase; $50.1M blocked	Pennsylvania Insurance Department (2025, as cited in project reports)	PID 2026 Individual and Small Group Rate Filing Summaries	insurance.pa.gov | High confidence
160,000+ policy terminations; 443,024 active enrollment 6/1/26	Pennie (2026, as cited in project reports)	Pennie Press Release, Feb. 9, 2026; Pennie enrollment reports	pennie.com | 1-844-844-8040 | High confidence
102% avg. net premium increase	Pennie/PID (as cited in project reports)	PID rate review documentation; Pennie affordability analysis	insurance.pa.gov | High confidence
All carrier approved rate changes	Pennsylvania Insurance Department (2025, as cited in project reports)	PID 2026 rate filing summaries (per-carrier)	insurance.pa.gov | High confidence
87% directory inaccuracy; 14.9% appointment rate; 190-day persistence; 33.2-day wait time	Texas A&M University (as cited in The Mirage of Care [Internal project report], 2026)	Texas A&M Univ. secret shopper study commissioned by PID; primary study NOT reviewed	PID public records request: insurance.pa.gov | Moderate confidence (see Note B)
40,000 recovery estimate; 9–12% premium reduction from Act 54 funding	Pennie actuarial projections (as cited in project reports)	Pennie actuarial memorandum; NOT directly reviewed	pennie.com | 1-844-844-8040 | Moderate confidence (see Note C)
County enrollment declines (Juniata 22.4%, Fulton 19.8%, Allegheny 15.7%, Philadelphia 15.5%)	Pennie modeled enrollment data (as cited in project reports)	Pennie enrollment modeling report; described as modeled estimates	pennie.com | Moderate confidence (modeled, not finalized)
12 network corrective actions Q1 2026; $10,000/violation fine exploration	Pennsylvania Insurance Dept., Q1 2026 (as cited in project reports)	PID Q1 2026 corrective action orders	insurance.pa.gov | Moderate confidence (orders not directly reviewed)
3 rural hospital L&D unit closures, early 2026	Project compilations (as cited)	Hospital system press releases; specific institutions NOT identified in compilations	Pennsylvania Hospital Assn: phalink.org | Low-Moderate confidence (see Note E)
2027 enrollment drift projection (5–10%); 50,000 additional disenrollments	Scenario modeling (as cited in project reports)	Pennie/PID scenario model; forward-looking	insurance.pa.gov | Low-Moderate confidence
All statutory and regulatory citations (Act 54, Act 252, 28 Pa. Code § 9.725, 45 C.F.R. §§ 149.410, 149.510, 156.140, 156.230, 29 U.S.C. § 1185a, et al.)	Directly cited primary authorities	Pennsylvania Legislature; U.S. Code; Code of Federal Regulations	pacodeandbulletin.gov; uscode.house.gov; ecfr.gov | High confidence

Note. Note E: The three rural hospital labor and delivery unit closure figure is reported in the source compilations but specific hospital identities are not identified. Verification requires contact with the

Pennsylvania Hospital Association (phalink.org) or review of hospital system announcements from early 2026.

References

Act 54 of 2024, Pa. Laws, Fiscal Code (Budget Year 2024–25) (establishing the State Health Insurance Exchange Affordability Program).

Act 252 of 2023, Pa. Laws (Network-Status Disclosure at Point of Service).

American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.

Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. BB, Title I (No Surprises Act). https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818.

Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a.

Patient Protection and Affordable Care Act, 42 U.S.C. § 300gg et seq. (2010).

28 Pa. Code § 9.725 (Hold-Harmless Protections against balance billing).

29 C.F.R. § 2590.712 (2013) (MHPAEA implementing regulations).

45 C.F.R. § 149.410 (2021) (Independent Dispute Resolution — surprise billing).

45 C.F.R. § 149.510 (2021) (IDR process and timelines).

45 C.F.R. § 156.140 (2022) (ACA actuarial value and plan variation).

45 C.F.R. § 156.230 (2015) (Qualified Health Plan network adequacy standards).

Pennsylvania Health Insurance Exchange Authority. (2026, February 9). One in five Pennie enrollees drop health coverage due to expired federal tax credits [Press release]. https://pennie.com

Pennsylvania Insurance Department. (2025). 2026 individual and small group rate filing summaries. https://www.insurance.pa.gov

Pennsylvania Insurance Department. (2025, November). 2025 transparency in coverage annual report. https://www.insurance.pa.gov

Internal Project Reports (secondary compilations; see Methodological Note A for classification rationale)

2026 Pennsylvania health insurance carrier rate analysis. (2026). [Internal project report].

2026 Pennsylvania health insurance market carrier rate analysis. (2026). [Internal project report].

2026 Pennsylvania health insurance market research report and its accompanying analytical frameworks. (2026). [Internal project report].

Navigating the 2026 Pennsylvania preventive-to-diagnostic insurance trap. (2026). [Internal project report].

Pennsylvania 2026 GLP-1 coverage and medical necessity standards. (2026). [Internal project report].

Pennsylvania 2026 health insurance market realignment analysis. (2026). [Internal project report].

Pennsylvania consumer advocacy and health billing protections. (2026). [Internal project report].

Pennsylvania ghost networks and rural mental health access. (2026). [Internal project report].

Pennsylvania health insurance exchange Act 54 eligibility framework. (2026). [Internal project report].

Pennsylvania health insurance: Forensic protocols and statutory protections. (2026). [Internal project report].

Pennsylvania insurance network adequacy and regulatory enforcement 2026. (2026). [Internal project report].

Pennsylvania Medicare trends and pharmaceutical policy 2026. (2026). [Internal project report].

Pennsylvania's stalled health insurance exchange affordability program. (2026). [Internal project report].

The 102% premium shock: Surviving Pennsylvania's 2026 "subsidy cliff." (2026). [Internal project report].

The 2026 federal network adequacy and geographic radius standards. (2026). [Internal project report].

The bronze migration and Pennsylvania's rural hospital crisis. (2026). [Internal project report].

The mirage of care: Pennsylvania's ghost network audit. (2026). [Internal project report].

The Pennsylvania EPO shift: Managed networks and market volatility. (2026). [Internal project report].

The Pennsylvania health insurance landscape (2026): A student's guide to geography and cost. (2026). [Internal project report].

The Pennsylvania preventive-to-diagnostic insurance billing trap. (2026). [Internal project report].

The Pennsylvania subsidy cliff: Enrollment contraction and market attrition. (2026). [Internal project report].

The Pennie health exchange affordability framework. (2026). [Internal project report].

The rise of EPO networks in Pennsylvania health insurance. (2026). [Internal project report].

The rural cliff: 2026 Pennsylvania health insurance enrollment trends. (2026). [Internal project report].

Upcoding and Pennsylvania medical premium inflation 2026. (2026). [Internal project report].

Official Contact Information for Primary Source Verification

Pennsylvania Insurance Department: 1-877-881-6388 | insurance.pa.gov

Pennie Exchange: 1-844-844-8040 | pennie.com

Federal CFR: ecfr.gov | Pennsylvania Code: pacodeandbulletin.gov | U.S. Code: uscode.house.gov

Pennsylvania Hospital Association (for hospital closure verification): phalink.org

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