

Drivers of 2024 Health Insurance Premium Changes

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Key Points

- Although Medicaid eligibility redeterminations due to the end of the COVID-19 public health emergency (PHE) will likely result in an increase in individual health insurance market enrollment, the impact on the risk pool and premiums is uncertain.
- Inflation and other factors will increase negotiated provider payment rates and will increase premiums.
- Shifting payment responsibility for COVID-19 vaccines and tests from the federal government to carriers could increase premiums, potentially offset by reduced carrier coverage of at-home tests.
- A continued shift of small groups from fully insured plans to other funding arrangements such as self-funded or level-funded plans could put upward pressure on small group premiums.
- Premium changes will reflect local market dynamics and vary by carrier and by area.

Introduction

Each year, the American Academy of Actuaries Individual and Small Group Markets Committee publishes an issue brief outlining the factors likely to drive premium changes for the next plan year. The issue brief focuses on changes in gross premiums, rather than changes in premiums net of premium subsidies. As with prior briefs, this year's brief examines factors that could affect the composition of health insurance risk pools, health care prices, and health care utilization, each of which could affect 2024 health spending projections and premiums.

Although the uncertainty in predicting health care utilization and spending created by the effects of COVID-19 pandemic has subsided, the end of the public health emergency (PHE) and changes in market regulations for 2024 introduce new sources of uncertainty into health spending projections. Most notable is the effect of Medicaid redeterminations due to the end of continuous coverage requirements tied to the COVID-19 PHE declaration.¹ Not only is the magnitude of the premium effects unknown, it is also unclear whether these changes would put upward or downward pressure on premiums. Regulators typically discourage rate adjustments unless carriers can justify rate changes, so these factors may have only minor effects on premiums for 2024.

Inflation and other contributors to higher negotiated provider payment rates will increase premiums for 2024.



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¹ "[Medicaid Enrollment and Unwinding Tracker](#)"; Kaiser Family Foundation; June 20, 2023.

COVID-19 Impacts on Claims Experience

The Affordable Care Act (ACA) rate review process requires issuers to develop premium rates based on the most recent year of experience, which is two years prior to the pricing plan year. Adjustments are then applied to reflect expected differences in claim costs between the experience year and the pricing plan year. In the case of 2024 rates, the 2022 benefit year is, in most cases, being used by carriers as the experience period.

By 2022, the effects of COVID-19 on claims experience primarily reflected the direct costs associated with COVID-19 vaccines, testing, and treatment. Care that was delayed or forgone in 2020 had rebounded by 2022, albeit at levels that may have been below pre-COVID levels.² It appears that COVID-19 has moved from a health care crisis, where costs were difficult to estimate, to more predictable ongoing costs. Nevertheless, there are a few COVID-related factors that can affect health spending projections and premiums.

COVID-19 Vaccine and Testing Costs

The PHE ended on May 11, 2023, prompting an array of changes in the costs of COVID-19 vaccines and tests that carriers and consumers face.³ In addition, the expected depletion of federally purchased vaccines and tests is expected to shift more of the costs to carriers and consumers.⁴

Beginning in January 2022, commercial health insurance carriers were required to cover the costs of at-home COVID-19 tests for the duration of the PHE. The rule had limited effect for most carriers because most consumers capitalized on free tests provided by the federal government. With the end of the PHE, carriers will no longer be required to cover the costs of at-home tests. Waning perceived need for testing could reduce the number of over-the-counter tests being purchased, reducing carrier costs. Some carriers may terminate coverage or implement cost-sharing for these tests, which would also reduce costs. Each of these developments would put downward pressure on premiums.

² [“How Has Healthcare Utilization Changed Since the Pandemic?”](#); Peterson-KFF Health System Tracker; Jan. 24, 2023.

³ [“What Happens When COVID-19 Emergency Declarations End? Implications for Coverage, Costs, and Access”](#); Kaiser Family Foundation; Jan. 31, 2023.

⁴ [“Commercialization of COVID-19 Vaccines, Treatments, and Tests: Implications for Access and Coverage”](#); Kaiser Family Foundation; Feb. 13, 2023.

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However, it is widely expected that once the federally purchased supply of vaccines and tests is depleted, commercial members will obtain these services via the commercial market. While the commercial prices for COVID-19 vaccines are not yet known, both Pfizer and Moderna have signaled likely ranges that are three to four times greater than the pre-purchased federal price for the bivalent booster. Carriers will be required to take on more of the cost of vaccines and tests, which could have an upward effect on premiums and/or consumer cost-sharing.⁵

Long COVID: Impact on Ongoing Medical Costs

Projections of the impact of long COVID on medical costs would typically consider that it is not a single condition but rather “a wide range of new, returning, or ongoing health problems that people experience after first being infected with the virus that causes COVID-19.”⁶ The most common symptom of long COVID is fatigue; however, there are a wide range of cases that involve damage to a variety of organ systems along with an increase in conditions requiring mental health services.⁷

One of the biggest uncertainties about long COVID is its impact on ongoing medical costs and future premiums. There is little known about how many people are affected by long COVID, how long it will last for those affected, and how it will impact their personal health. Increased medical spending is likely a consequence of long COVID. It is expected that any increases to premiums due to long COVID will vary by carrier and by region, based on the underlying demographics of the enrollees and the local prevalence of COVID.

Changes in Risk Pool Composition—Individual Market

The resumption of Medicaid eligibility redeterminations is a potential 2024 premium driver in the individual market, due to the impact on the composition of the insurance risk pools. Estimates of the number of Medicaid enrollees who could lose coverage due to the redeterminations range from 8 million to 24 million.⁸ Some individuals losing Medicaid may be eligible for the American Rescue Plan Act’s (ARPA) enhanced premium subsidies, which have been extended through 2025, and may enroll in the individual market. Others losing coverage may obtain group coverage through an employer, while others may choose not to enroll in any coverage, either due to the lack of available subsidies or personal choice. It’s unclear whether a shift from Medicaid to the individual market will improve or worsen the risk pool in the individual market and how that could vary by state, for instance depending on whether the state expanded Medicaid.

⁵ “[How Much Could COVID-19 Vaccines Cost the U.S. After Commercialization?](#)”; Kaiser Family Foundation; March 10, 2023.

⁶ “[Long COVID or Post-COVID Conditions](#)”; Centers for Disease Control and Prevention; Dec. 16, 2022.

⁷ “[The Costs of Long COVID](#)”; *JAMA Forum*; May 12, 2022.

⁸ “[How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?](#)”; Kaiser Family Foundation; April 26, 2023.

Any change in the individual market risk pool will depend on the morbidity of those shifting from Medicaid to individual market coverage relative to the morbidity of the current individual market risk pool as well as the magnitude of those shifting coverage relative to current individual market enrollment. Although people losing Medicaid coverage due to having income too high to meet eligibility requirements may be healthier than the those who remain eligible for Medicaid, they may or may not be healthier on average than current individual market enrollees. Carriers may make minimal changes to their assumptions regarding the individual market risk pool for the 2024 plan year and reflect any changes in their 2025 premiums, after they have more information regarding the impact of Medicaid redeterminations.

Changes in assumptions may occur, however, with respect to the percentage of individual market enrollees who are eligible for cost-sharing reductions (CSRs). An influx of prior Medicaid enrollees could increase the share and distribution of individual market enrollees who are eligible for CSRs, which could change carriers' CSR loads in states that have not required a specific CSR load.

Changes in Risk Pool Composition—Small Group Market

The resumption of Medicaid eligibility redeterminations may also be a 2024 premium driver in the small group market. Some of those losing coverage may already be enrolled in small group plans in addition to Medicaid, and other members may enroll in a small group plan following loss of Medicaid coverage. At this time, the impact on the risk pool is unclear.

Shifts in the utilization of alternative plan funding arrangements, other than ACA-compliant fully insured small group coverage, can contribute to changes in the composition of the small group market risk pool, as can decisions by small employers to stop offering coverage altogether. The impacts may vary by local market due to competitive dynamics and differences in regulations by state.

Small employers continue to migrate toward alternative funding arrangements, including level-funded plans, self-funded plans, multiple employer welfare arrangements (MEWAs), and association health plans. For instance, according to the Kaiser Family Foundation, the percentage of covered workers at small firms (3-49 workers) enrolled in a self-funded or level-funded plans increased from 21% in 2019 to 41% in 2022.^{9,10} Under these arrangements, health status may be used to determine premium rates. As a result, these options can be a lower-cost offering for small groups with lower morbidity than that of

⁹ “[2019 Employer Health Benefits Survey](#)”; Kaiser Family Foundation; Sept. 25, 2019.

¹⁰ “[2022 Employer Health Benefits Survey](#)”; Kaiser Family Foundation; Oct. 27, 2022.

the fully insured single risk pool. If small employers continue to migrate into alternative funding arrangements, the morbidity of the remaining small group fully insured risk pool would be expected to deteriorate, resulting in higher premium rates.

General inflation, including wage inflation, continues to remain elevated, putting significant cost pressure on small groups.¹¹ It remains to be seen whether small employers will stop offering coverage, reduce levels of coverage, or decrease employer contributions to mitigate continued increases in their other business expenses. Any changes could vary by industry as well as geographic area. If small employers reduce their commitments to providing health coverage, the small employers that choose to stay in the fully insured ACA markets may do so because their plan population is of higher than-average morbidity.

Some small employers may also choose to stop offering health insurance coverage and use Individual Coverage Health Reimbursement Accounts (ICHRA) or Qualified Small Employer HRA (QSEHRA) to fund a portion of their employee's health insurance premiums. It is difficult to gauge what impact such movement into ICHRA or QSEHRA could have on premium rates in the small group fully insured market as both groups with higher-than-average and lower-than-average risk could see benefits in this strategy.^{12,13}

State-Based Considerations

Affordability in the individual market and the small group market remain a concern in many states, leading state policymakers to initiate mechanisms to reduce premium rate increases for populations of interest. At the same time, state policymakers are also concerned as to what benefits are covered and may also mandate new covered services. Such requirements to cover additional services would increase premium rates. State policymakers are also considering or enacting other operational changes that could impact premiums.

State initiatives have included:

- *State “public options.”* Three states (Washington, Colorado, Minnesota) have implemented or are in the process of implementing requirements for private carriers to offer public option style plans. Although the specific requirements vary by state, the aim is for these plans to contain costs by capping payments to providers or by requiring plans meet specific premium reduction thresholds.¹⁴ Carriers in these markets will monitor state actions to determine the effect that these changes may have on their specific book of business.

¹¹ [“Small Business Owners Express Great Concern for Future Business Conditions”](#); NFIB Research Foundation; May 2023.

¹² [“2022 Employer Health Benefits Survey—Summary of Findings”](#); Kaiser Family Foundation; Oct. 27, 2022.

¹³ [“Small Business Owners Express Great Concern for Future Business Conditions”](#); Op. cit.

¹⁴ [“Update on State Public Option-Style Laws: Getting to More Affordable Coverage”](#); The Commonwealth Fund; March 29, 2022.

- *Reinsurance.* In the individual market, numerous states have implemented reinsurance programs through section 1332 waivers. Reinsurance programs result in premiums lower than they would be otherwise, but beyond the first year of the reinsurance program the rate of premium growth is less affected. In 2023, reinsurance programs were newly implemented in Idaho (individual market),¹⁵ Virginia (individual market),¹⁶ and Maine (merged individual and small group markets).¹⁷ New York recently submitted a 1332 waiver application that includes a reinsurance program.
- *Other state-specific policy changes.* To the extent that particular states are implementing policies that impact access, affordability, and equity in the individual and small group markets, carriers would assess the extent to which such changes would affect premiums.

Provider Reimbursement Rates and Telemedicine

Recently health care costs have been increasing at a rate above that of inflation.¹⁸ The reimbursement rates that carriers negotiate to pay providers are contracted in advance and are typically set on a multiyear basis. As these contracts come up for renewal, contracted rates are likely to increase significantly due to increases in the operational costs of providers. The effect of inflation will likely be reflected in increased contract rates that take effect in 2023 and beyond as prospective contracting catches up with inflation. In addition, health systems are facing high rates of turnover and staff burnout due to staffing shortages.¹⁹ High demand and competition for this staff and union negotiations may result in salary increases that exceed inflation. These factors will contribute to premium increases.

Medicare reimbursement rates serve as the basis for many organizations' negotiations with providers to inform their contracted rates for providing services to individual and small group members (i.e., non-Medicare beneficiaries). For example, a carrier may contract with a hospital system to pay 150% of the Medicare rate for inpatient services. If the changes in Medicare rates are not keeping up with provider costs in the market, providers may further increase their negotiated reimbursements with private payers above those that, in general, are already substantially more than Medicare allowable reimbursements. For instance, inflation adjustments for Medicare payments tend to

¹⁵ ["Idaho Section 1332 Waiver Application"](#); Idaho Department of Insurance; May 5, 2022.

¹⁶ ["Commonwealth of Virginia 1332 State Innovation Waiver Application to Establish a State Reinsurance Program"](#); Commonwealth of Virginia State Corporation Commission, Bureau of Insurance; Dec. 31, 2022

¹⁷ ["State of Maine Executive Summary and Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act"](#); State of Maine Department of Professional and Financial Regulation, Bureau of Insurance; May 9, 2018.

¹⁸ ["How does medical inflation compare to inflation in the rest of the economy?"](#); Kaiser Family Foundation; March 29, 2023.

¹⁹ ["AHA Letter Re: Challenges Facing America's Health Care Workforce as the U.S. Enters Third Year of COVID-19 Pandemic"](#); American Hospital Association; March 1, 2022.

lag costs due to the long lead time necessary to establish rates. As a result, the ratio of commercial payment rates to Medicare can change over time.

Telemedicine may continue to play a role in health care utilization. Prior to the pandemic, telemedicine utilization was marginal in large part due to a patchwork of state regulatory approaches. During the pandemic, federal policies were put in place to broaden access to telemedicine, and usage increased significantly. Although telemedicine usage has receded, it remains well above pre-COVID-19 levels.²⁰ While some federal policies have been extended, others have not. It will be important to consider changes that may occur at a state or federal level. The overall impact of the increased use of telehealth services on premium levels remains uncertain, however, as it's still unclear whether telemedicine reduces utilization of more traditional services or will increase spending overall. In addition, effects could vary by state depending on state-specific payment parity laws.²¹

Standardized Plan Requirements

In 2024, federal rules require that carriers offering plans in states using the federal platform must offer standard plans and are limited to four non-standard plans per network product type/metal level/service area. States using their own platforms may have different requirements for standardized plan offerings. Standardized plan requirements and limitations on the number of non-standardized plans could result in carriers reconfiguring their product offerings, which could in turn impact the carrier's enrollee risk profile. Some carriers only offer a small number of plans in a state. These carriers may have to increase their plan offerings to satisfy finalized standardized plan option requirements, which may attract a different set of members. Other carriers offer many products to attract and meet the needs of various members. If specialized plans are discontinued due to the restrictions on the number of non-standardized plans, the risk profile could also shift. Although risk adjustment is intended to compensate for differing risk profiles, it is not perfect. Actuaries that project changes to the overall market risk profile are unlikely to change their projected risk transfer amounts to nullify any projected premium increases or decreases. The impact of changes in a carrier's product offerings may or may not be incorporated into 2024 premiums.

It is also important to consider the provider networks associated with the standard plans and the remaining non-standard plans, even within network product type categories. If the standard plans and remaining non-standard plans have narrower networks than plans that were discontinued, there could be some downward pressure on average premiums.

²⁰ [Updated National Survey Trends in Telehealth Utilization and Modality \(2021-2022\)](#); U.S. Department of Health and Human Services; April 19, 2023.

²¹ [States Provide Payment Parity for Telehealth and In-Person Care](#); The National Academy for State Health Policy; Aug. 25, 2021.

If low-cost plans are discontinued, the second-lowest silver plan may change, with impacts for exchange subsidies. If the restriction of the number of non-standardized plans results in either the high-cost plans or the low-cost plans being discontinued, the state average premium may change.

Summary

Rate setting in the ACA-compliant individual and small group markets is complex, and pricing actuaries consider a wide range of factors when determining rate levels. How 2024 premiums will differ from those in 2023 depends on many factors. When developing 2024 health insurance rates, carriers are likely to project claims under multiple scenarios due to the uncertainty regarding the impacts of various factors, including the effects of Medicaid eligibility redeterminations. Although Medicaid eligibility redeterminations will likely result in an increase in individual health insurance market enrollment, the impact on the risk pool and premiums is uncertain.

Perhaps more certain is that inflation and other factors will increase negotiated provider payment rates and will increase premiums.

Other factors that could affect 2024 premiums include the shifting payment responsibility for COVID-19 vaccines and tests from the federal government to carriers. This shift could increase premiums, potentially offset by reduced carrier coverage of at-home tests. In addition, a continued shift of small groups from fully insured plans to other funding arrangements such as self-funded or level-funded plans could put upward pressure on small group premiums.

Finally, all health care is local, and rate changes will likely vary between individual and small group plans within the same geographic area, as well as variations between geographic regions.

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