MILLIMAN WHITE PAPER

Early ICHRA insights

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Despite inherent differences in traditional employer-sponsored group insurance and ICHRAs, moving to an ICHRA doesn't seem to have a significant impact on overall plan participation.

Individual coverage health reimbursement arrangements—ICHRAs for short—offer an alternative to the traditional employer-sponsored group health plan by allowing employers of any size to reimburse employees' premium on a pretax basis for health insurance they purchase individually. As an earlier paper authored by Lauren Efferding detailed, enrollment in the individual marketplace continues to grow, with nearly 3 million new enrollees in 2022.[1] Additionally, according to Ideon (formerly Vericred), nearly half of the United States is classified as "ICHRA-friendly," meaning individual plan premiums are comparable or less expensive than small group plan premiums for plans within the same metallic tier.[2]

As ICHRAs gain traction among employers, we set out to see what conclusions we could draw from our clients electing this type of arrangement. Would the behavior of early adopters help us predict enrollment, provide guidance on when to offer an ICHRA, and establish parameters for a successful rollout, thereby increasing employee satisfaction with benefits? To attempt to answer these questions and others, we analyzed enrollment data from 57 employers representing approximately 4,000 benefits-eligible employees who were under the age of 65.

Our analysis is primarily focused on the employers that sponsored a traditional group health plan in 2021 before adopting an ICHRA for 2022. This consisted of 38 employers representing approximately 3,600 employees. We've included a brief section at the end of this paper summarizing our key findings related to the enrollment characteristics of the remaining 19 employers. Overall, our research found that, despite inherent differences in traditional employer-sponsored group insurance and ICHRAs, moving to an ICHRA doesn't seem to have a significant impact on overall plan participation, as we'll discuss in detail.

What factors influence employee participation?

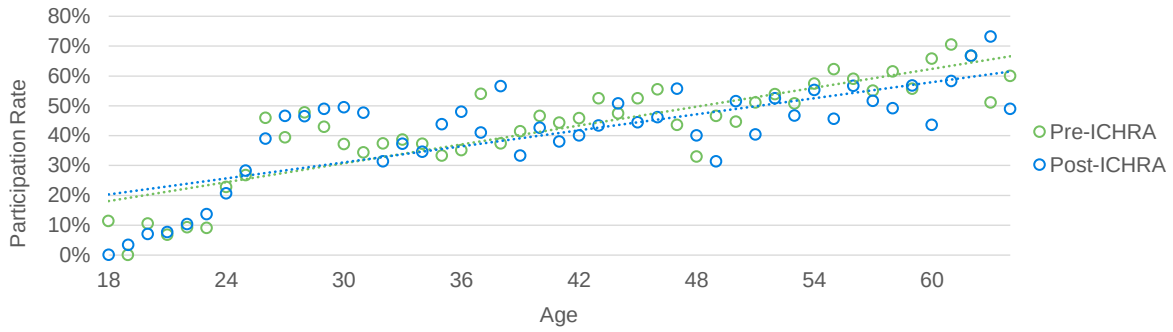
Overall, participation in an employer-sponsored health plan remained virtually unchanged after moving to an ICHRA—41% before and after. The demographic profile of the group also remained nearly identical.

Age proved to be a better indicator of participation than other demographic factors we analyzed, such as income and geography, with older individuals more likely to elect coverage, despite age-rated premiums in most states' individual markets.

[1] For more information, see https://www.milliman.com/en/insight/leveraging-ichra-for-employer-groups.

[2] Ideon (December 2021). Interactive Map: 2022 ICHRA-Friendly States. Retrieved August 5, 2022.

FIGURE 1: AVERAGE PARTICIPATION RATE BY AGE OF EMPLOYEE



There was also a positive correlation between income and participation, but to a much lesser extent.

Participation varied by region, both under traditional group and ICHRA, with the Midwest having the highest average participation rate before and after ICHRA. On average, participation rates increased by 4% for employers located in the Northeast but decreased by 2% to 6% for employers located in the remaining three regions.

FIGURE 2: PARTICIPATION RATES BY GEOGRAPHIC REGION

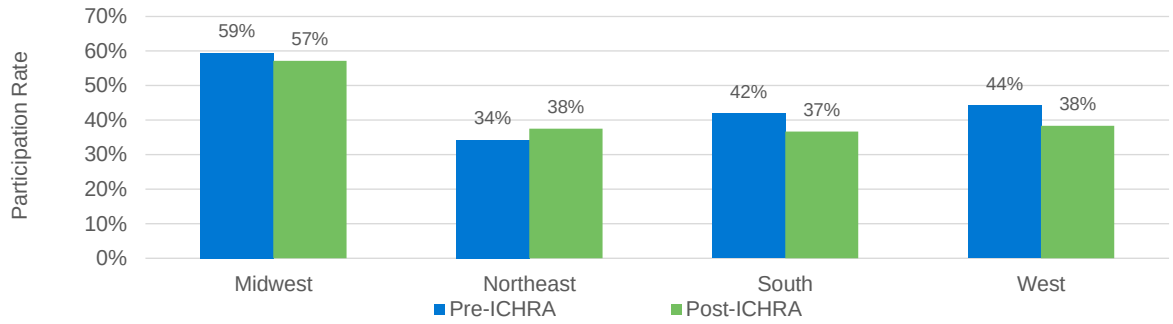


Figure 3 shows a comparison of median per employee per month (PEPM) employer subsidy amounts for employees that enrolled in coverage versus those who did not. As expected, higher employer subsidies encouraged participation. There was an average $75 per month difference in the available employee-only subsidy between ICHRA enrollees ($325 per month) and waivers ($250 per month). We were surprised to find that the median employer subsidy for enrollees post-ICHRA was considerably lower than it was pre-ICHRA. This could be a result of lower overall premiums in the individual market. as discussed later.

FIGURE 3: MEDIAN EMPLOYER SUBSIDY LEVELS FOR ENROLLED AND WAIVED EMPLOYEES

	PRE-ICHRA		POST-ICHRA	
COVERAGE TIER	**ENROLLED**	**WAIVED**	**ENROLLED**	**WAIVED**
Employee Only	$455	$470	$325	$250
Employee + Spouse	$715	$935	$530	$425
Employee + Child(ren)	$715	$935	$500	$420
Employee + Family	$1,075	$1,240	$620	$510

We also considered group size and industry, but there were no discernible relationships between those categories and participation in ICHRA.

What types of plans are employees enrolling in?

In general, employees are electing less rich plans—e.g., higher deductibles, copays, and out-of-pocket (OOP) maximums—when they move to an individual plan. Figure 4 displays a high-level comparison of the median plan design elements based on plan elections before and after ICHRA implementation.

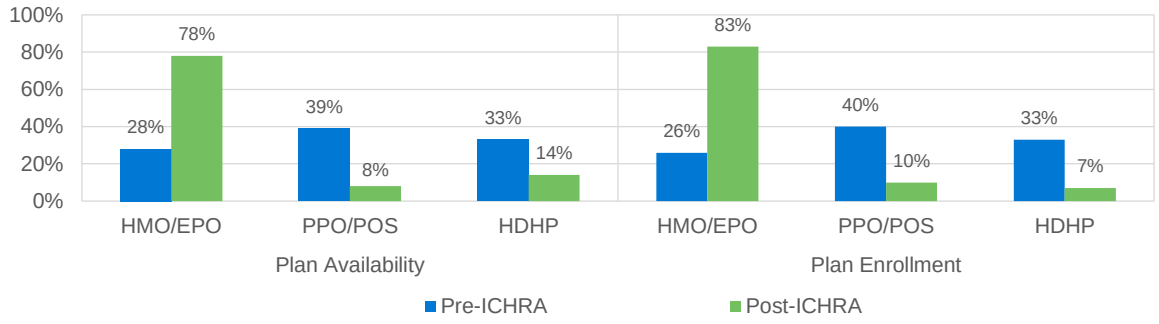
FIGURE 4: MEDIAN PLAN DESIGN BY PLAN TYPE

	HMO/EPO		PPO/POS		HDHP	
	PRE-ICHRA	POST-ICHRA	PRE-ICHRA	POST-ICHRA	PRE-ICHRA	POST-ICHRA
Deductible	$3,250	$3,250	$2,250	$3,000	$4,000	$5,000
Coinsurance	10%	15%	10%	15%	10%	15%
OOP Maximum	$5,000	$7,750	$5,750	$8,000	$4,750	$7,750

The amounts shown are based on the in-network benefit for plans that offered out-of-network benefits.

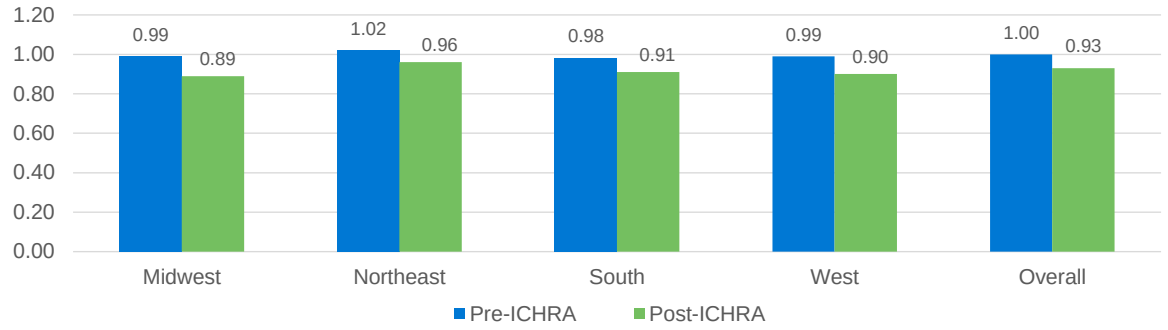
Figure 5 shows the distribution of plans by plan type based on the number of plans available as well as the plan enrollment. Health maintenance organization (HMO)/exclusive provider organization (EPO) plans comprised only 28% of all plans offered under traditional group coverage. This is nearly the opposite on the individual market, where 78% of available plans were HMO/EPO. It is no surprise then that enrollment shifted from 26% HMO/EPO before ICHRA to 83% after.

FIGURE 5: DISTRIBUTION OF AVAILABILITY AND ENROLLMENT BY PLAN TYPE



A comparison of the relative plan value by geographic region is shown in Figure 6. On average, the benefit plans elected by employees after ICHRA were 7% less rich (e.g., higher average deductibles, OOP maximums, and copays) than the elected plans prior to ICHRA. We measured benefit plan richness by running each plan design through Milliman's proprietary pricing models, assuming a similar degree of healthcare management and discounts for all plans. This allowed us to determine the relative value of benefits from the plans' perspective. It does not account for any differences in provider networks.

FIGURE 6: RELATIVE PLAN VALUE BY GEOGRAPHIC REGION



All plan values are measured relative to the average pre-ICHRA plan value.

Figure 7 shows a comparison of the enrollment distribution by metallic tier while Figure 8 displays the same distribution but in terms of the employees' change in metallic tier before and after ICHRA. Approximately 45% of the enrollees elected a plan that fell into a lower metallic tier than that of their previous plan. One plausible explanation is that nearly half of the employees carried a level of insurance prior to ICHRA that was more than they thought necessary and opted to "buy down" to a plan better suited to their needs. For employees "buying up" after moving to ICHRA, approximately half were previously enrolled in a bronze plan.

FIGURE 7: ENROLLMENT DISTRIBUTION BY METALLIC TIER

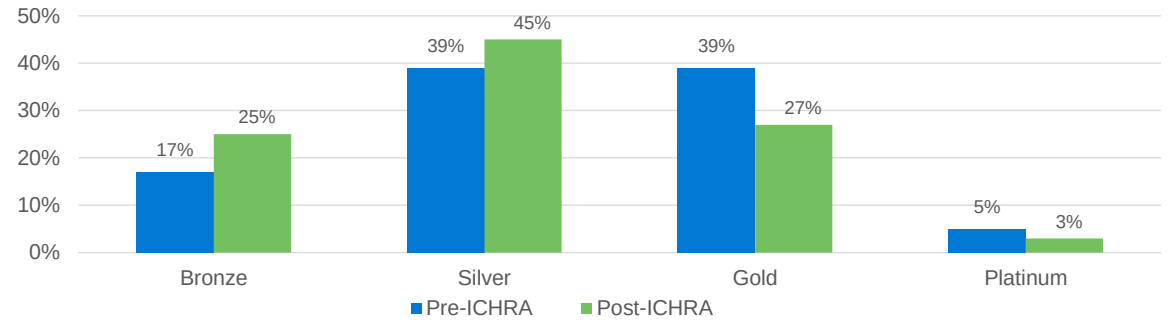
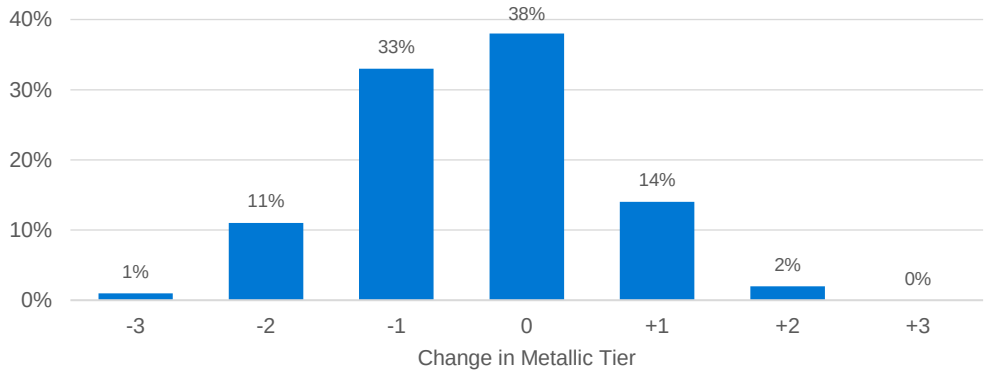


FIGURE 8: ENROLLMENT DISTRIBUTION BY CHANGE IN METALLIC TIER AFTER MOVING TO ICHRA



Percentages may not add to 100% due to rounding.

The enrollment trend from higher to lower metallic-tier plans is due in part to the average availability of bronze and silver plan options before moving to ICHRA, which is illustrated in Figure 9. Before ICHRA, over half of the plans available to the average employee were at a gold or platinum level, while only 28% of plans fell into these metallic tiers after ICHRA.

FIGURE 9: AVERAGE PLAN AVAILABILITY BEFORE AND AFTER ICHRA

	AVERAGE NUMBER OF PLANS AVAILABLE		PERCENT OF TOTAL PLANS AVAILABLE	
METALLIC TIER	**PRE-ICHRA**	**POST-ICHRA**	**PRE-ICHRA**	**POST-ICHRA**
Bronze	0.23	22.64	13.5%	29.6%
Silver	0.61	32.52	35.3%	42.6%
Gold	0.84	15.46	48.7%	20.3%
Platinum	0.04	5.73	2.5%	7.5%
Total	1.72	76.35	100.0%	100.0%

We found no strong correlation between the age of employees and actuarial value of the plans they elected. The correlation was slightly stronger between income level and actuarial value but still not significant.

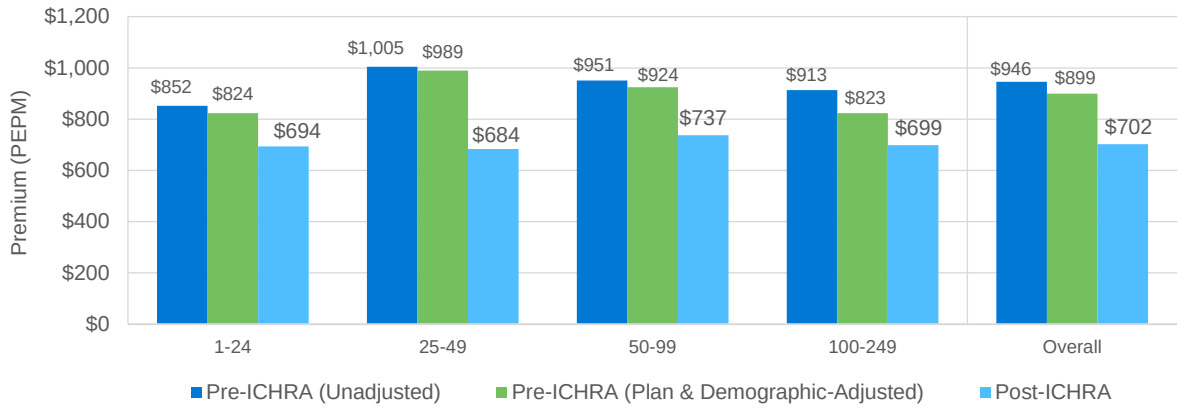
How does cost impact enrollment?

For every segment we evaluated, employees chose a plan with a lower price tag than the total premium rate of their previous group health plan.

Figure 10 displays a comparison of the premium PEPM before and after ICHRA and is categorized by size of employer. Before adjusting for differences in plan richness and demographics, the average premium was 26% lower in the post-ICHRA period. After adjusting for differences in plan design and demographics, the average premium savings was reduced to 22%. The reduction in premium savings is primarily due to employee “buy-down” into plans that were lower in actuarial value than their previous group plan. In other words, employees chose plans that provided less coverage (higher deductibles, larger coinsurance share) or more restrictions (smaller network of providers, fewer covered services) in exchange for a lower premium.

The premium amounts shown in Figure 10 were adjusted for plan design using an estimated plan value differential derived from Milliman’s Managed Care Rating Model, while the demographic adjustment was based on the Patient Protection and Affordable Care Act (ACA) premium age curves. We believe this methodology is representative of what the pre-ICHRA premiums would have been had the previous group plans been offered in the individual/ACA market. It’s important to note that the estimated plan value differential was based on the primary employee cost-sharing elements of the plans (e.g., deductibles, OOP maximums, coinsurance, copays). While there are other factors that ultimately affect the premium of a health plan, such as the provider reimbursement arrangement, utilization management, and cost containment programs, etc., these factors were outside the scope of this analysis and were not accounted for in the following figures.

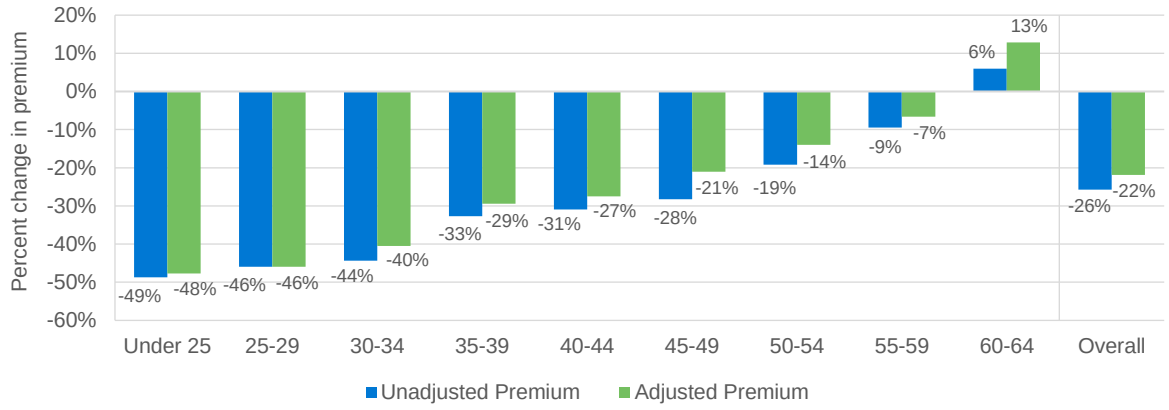
FIGURE 10: AVERAGE PER EMPLOYEE PER MONTH (PEPM) BY SIZE OF EMPLOYER



Adjusted Pre-ICHRA premium amounts have been adjusted to reflect differences in plan selection and demographics between the pre-ICHRA and post-ICHRA time periods.

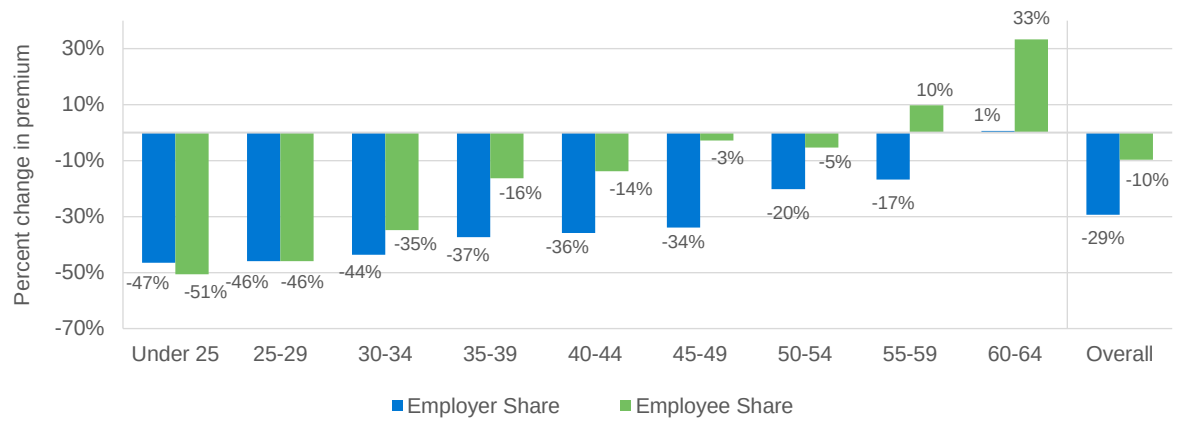
Figure 11 shows the average change in premium by employee age group. Like Figure 10, the percentages shown in Figure 11 are based on average premium amounts with (adjusted) and without (unadjusted) consideration of differences in the plan selection and demographics of the enrollee populations before and after ICHRA. Apart from the 60-64 age group, the average premium was lower post-ICHRA for all age categories, with average premium decreasing by as much as 49% (48% on an adjusted basis) for employees under 25. Not surprisingly, premium decreases were most pronounced for younger employees while premium increases were common for older employees. Most states require individual market premiums to be set based on the ages of all covered members, while nearly all employers in our analysis varied pre-ICHRA premiums by only plan design and coverage tier. All but one of the employers that we evaluated paid premiums that were the same for all ages and varied only plan and coverage tier prior to moving to ICHRA.

FIGURE 11: AVERAGE PREMIUM (PEPM) CHANGE BY EMPLOYEE AGE



The average change in the employers' and employees' share of the total plan and demographically adjusted premium is shown in Figure 12. Overall, the employers' and employees' cost decreased after moving to ICHRA. Compared to pre-ICHRA levels, employers saved an average of 29% while employee savings were 10%. When comparing the average premium changes across all age ranges, employees under the age of 55 typically contributed less than they did previously while employees in the 55-59 and 60-64 age categories paid 10% and 33% more, respectively. The average employer subsidy (in dollar terms) decreased for all age categories except for the 60-64 age category.

FIGURE 12: AVERAGE EMPLOYER SUBSIDY AND EMPLOYEE CONTRIBUTION (PEPM) CHANGE BY EMPLOYEE AGE



Estimated based on the average split between employers' and employees' shares of overall pre-ICHRA premium.

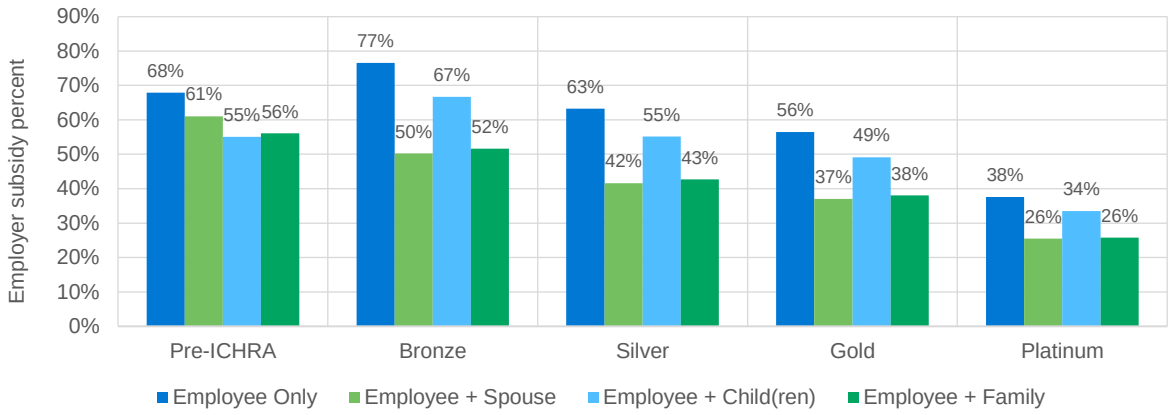
We also looked at median employer subsidy and employee contribution levels based on all plans available to employees in their respective states' marketplaces. This information is shown in Figure 13.

While the average employer subsidy amount was higher before moving to ICHRA, employees generally contributed less from their paychecks post-ICHRA due to lower individual market premiums. This is further illustrated in Figure 14—the employer subsidy, on a percentage basis, decreased for most combinations of coverage tier and metallic tier level post-ICHRA. However, given the higher overall premium levels before ICHRA, the employees' dollar share of premium represented a lower percentage of their incomes after ICHRA. Employee + Spouse was the only coverage tier that required employees to pay a higher dollar contribution post-ICHRA. The employer subsidy percentage dropped the most here as well. This could be a result of a generally higher average age resulting in higher relative premiums on the individual market. Unlike the charts above, the tables below are based on all employees and not just those enrolled. It should be noted that, when the total premium is less than the employer subsidy, employees do not typically get to keep the difference.

FIGURE 13: MEDIAN EMPLOYER SUBSIDY AND EMPLOYEE CONTRIBUTION (PEPM)

	PRE-ICHRA				POST-ICHRA			
	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE+ CHILD(REN)	EMPLOYEE + FAMILY	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Employer Subsidy	$462	$937	$739	$1,107	$290	$458	$450	$546
Employee Contribution	$218	$598	$602	$867	$187	$689	$399	$786
Employee Contribution / 150% of FPL	13%	26%	21%	25%	11%	31%	15%	24%
Employee Contribution / 400% of FPL	5%	10%	8%	9%	4%	12%	5%	9%

FIGURE 14: MEDIAN EMPLOYER SUBSIDY PERCENTAGE

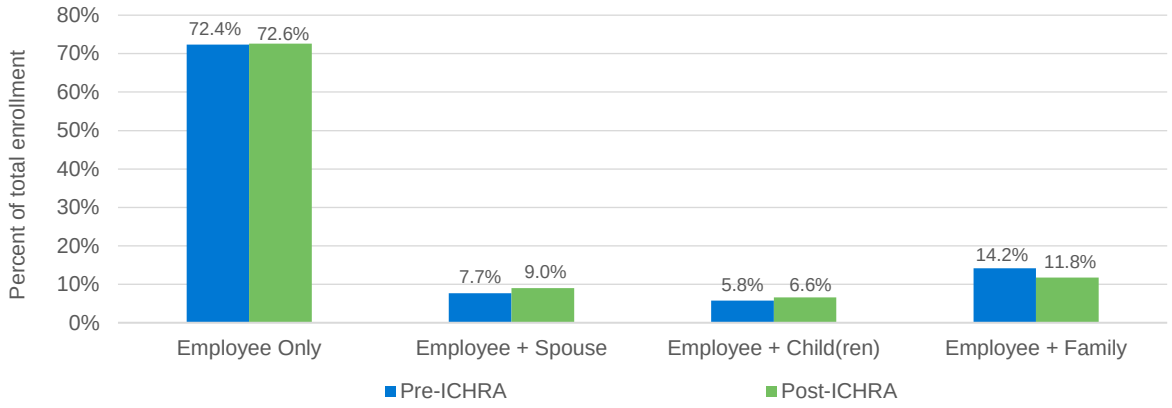


What else did we consider?

The above categories only scratch the surface of data points we could have analyzed. Given the relative newness of ICHRAs, we did not believe we had a credible data set yet to dive deeper. As we see enrollment increase, we will update these findings and add to the depth and breadth of our analysis. Meanwhile, a couple other areas we investigated follow.

We expected to see proportionately more employees enrolled in the employee-only tier after ICHRA, supposing that coverage would be more affordable for younger employees who were less likely to cover dependents. However, based on the chart in Figure 15, that was not the case. Additionally, enrollment in the Employee + Family tier shifted slightly to other coverage tiers.

FIGURE 15: ENROLLMENT DISTRIBUTION BY COVERAGE TIER



We also expected ICHRA enrollment would be higher when employees had access to the same carrier that issued their prior group plans. Once again, we were surprised to find that was not the case.

Did enrollment characteristics differ between employers that previously offered coverage compared to those that did not?

As referenced previously, 19 employers included in our data set did not offer group health insurance prior to adopting an ICHRA. Comparing the enrollment characteristics of these employers to the employers that previously offered health insurance, the areas that differed most notably include:

Participation rates. On average, the participation rate was less than half the participation rate for employers that previously offered health insurance—20% versus 41%.

Enrollment distribution by coverage tier. Nearly 80% of enrollment was in the employee-only coverage tier for these employers.

Enrollment distribution by metallic tier. Forty-five percent of employees enrolled in a gold-level plan (compared to 27% for employers that previously offered health insurance).

Employer subsidies. While not uncommon, these employers were less likely to vary PEPM employer subsidy amounts by coverage tier. As a result, the median employer subsidy was slightly higher (6%) for the employee-only tier but significantly lower (25% to 40%) for all other tiers. The higher percentage of employee-only enrollees for this group is likely a byproduct of a flat-dollar employer subsidy strategy.

So what did we learn from this analysis?

First, changing from traditional group insurance to an ICHRA model had little impact on overall participation; however, older employees are more likely to enroll in an ICHRA than younger employees despite generally having to pay more. Second, enrollees are generally electing more prevalent HMO/EPO plans on the individual market and are often buying down from their current coverage. Third, when individual plans are less expensive, employers contribute lower monthly subsidies and reduce their benefits budget.

With the growing number of individual market enrollees,[3] coupled with recent growth in the number of carrier and plan options available,[4] we anticipate more employers will sponsor an ICHRA. As this happens, we will continue to monitor available options and employee behavior. Contact your Milliman consultant with any questions or to see whether ICHRA might be a good fit for your organization.

Data reliance and caveats

We relied on data provided to us and decisions communicated to us by the employer groups in our data set. We have not audited this data, but we performed a limited review for reasonableness, and we found no material defects in the data used in this report. If the underlying data is inaccurate or incomplete, then the results of our review may be inaccurate or incomplete.

Differences between our analysis and actual results depend on the extent to which future behavior conforms to the assumptions made for this analysis. It is likely that actual results by individual employer group will not conform exactly to the results presented here.

This paper has been prepared to share our early findings from clients adopting an ICHRA and should not be relied on for anything other than its intended purpose.

[3] Over 14.5 million consumers (up 2.5 million compared to 2021) selected or were automatically reenrolled in health insurance coverage through HealthCare.gov and state-based marketplaces during the 2022 open enrollment period. See https://www.cms.gov/files/document/health-insurance-exchanges-2022-open-enrollment-report-final.pdf (retrieved August 10, 2022).

[4] Based on analysis of exchange plan and issuer-level information for states participating in the Federally-facilitated Exchanges (FFE) as well as states operating their own exchanges.

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