Impact of Individual Coverage Health Reimbursement Arrangements on Employees with Group Health Coverage

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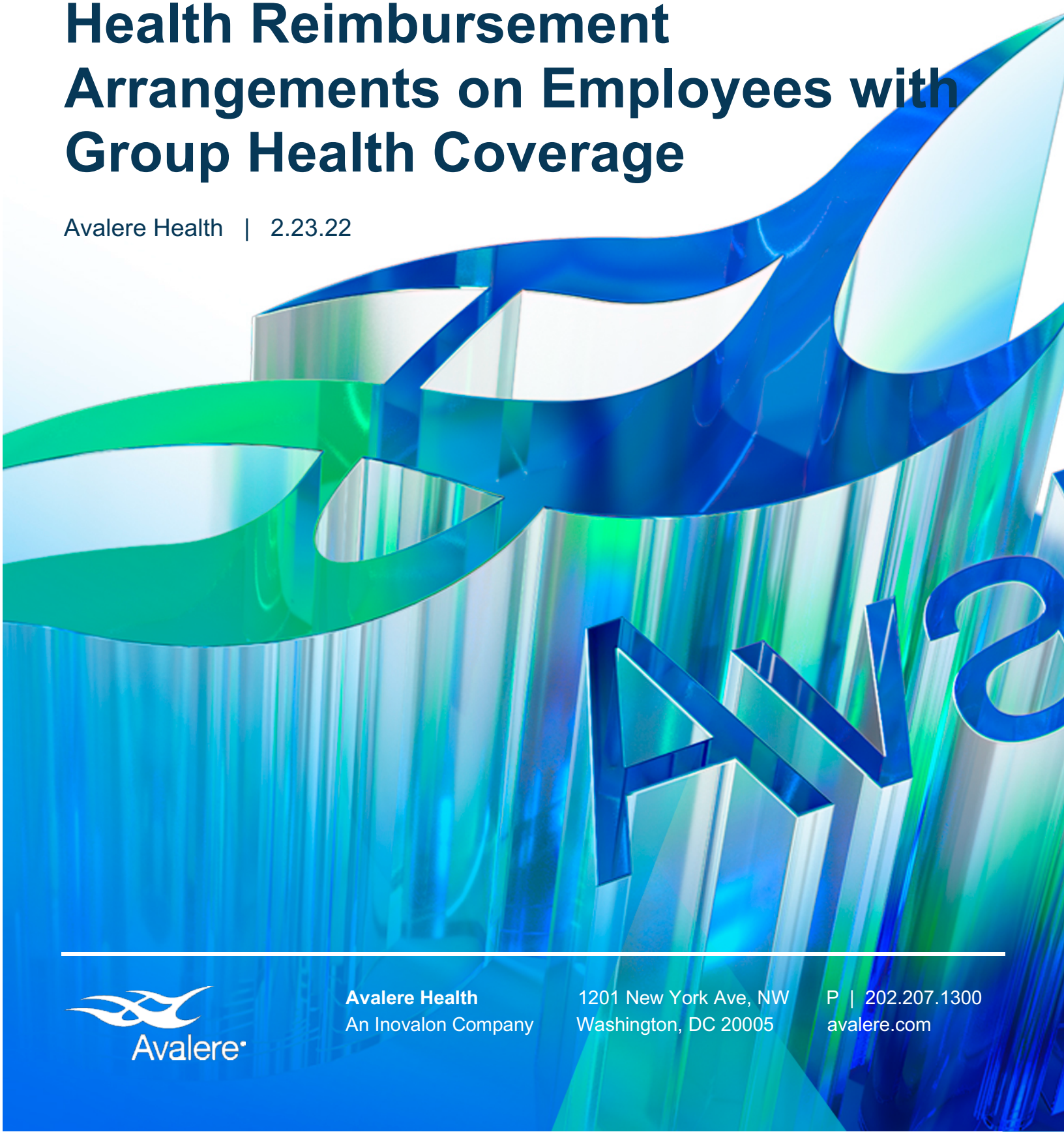

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Executive Summary

An individual coverage health reimbursement arrangement (ICHRA) allows employers to provide employees with funds to purchase health insurance on the individual health insurance market, including exchanges. Employees may use these funds to pay for premiums, including Medicare premiums. Employers also may choose to allow their employees to use these funds to cover certain out-of-pocket (OOP) costs.

Health reimbursement arrangements (HRAs) were first defined in federal regulation in 2002. ICHRAs were introduced in a 2019 regulation, allowing employers to offer these arrangements instead of group health plan coverage. In that rule, the Internal Revenue Service (IRS), the Employee Benefits Security Administration (EBSA), and the Department of Health and Human Services (HHS), together referred to as the tri-agencies, described ICHRAs as a way to expand flexibility and provide additional options for employers to offer healthcare coverage. At the time the rule was issued, some stakeholders, including some patient and provider groups, raised concerns that the rule does not sufficiently protect workers from discrimination, and that ICHRA enrollment could negatively impact the Affordable Care Act (ACA) risk pools in the future.[1]

In this paper, Avalere analyzes likely enrollment shifts from group health plans, which covered approximately 125 million people employed by private companies in 2021, to ICHRAs.[2,3] The analysis, focused on 2021 and 2022 enrollment, indicates that approximately 2 million employees are enrolled on individual market plans funded by ICHRAs. Employee ICHRA enrollment is expected to grow to 3.1 million in 2022, with higher total enrollment expected when accounting for spouses and dependents. Utilizing this analysis, Avalere describes considerations for policymakers, employers, labor organizations, and other stakeholders. Factors considered include premium affordability (including whether an ICHRA offer could cause individuals to lose access to advance premium tax credits and cost-sharing reductions), enrollee out-of-pocket costs (OOP), provider coverage, and access to services.

1 CMS. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. IRS, EBSA, and HHS. June 20, 2019. Link
2 Congressional Budget Office. “Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030”. September 29, 2020. Link.
3 Bureau of Labor Statistics. National Compensation Survey: Employee Benefits in the United States, March 2021. Link

Overview

HRAs were originally conceived as a way to reimburse employees with pre-tax dollars for qualified medical expenses that were not covered by their group health plan. Since then, regulatory guardrails for HRAs have evolved and employers' HRA options have expanded. Key policy changes related to the evolution of HRAs include:

- **In 2002**, the IRS issued a notice and revenue ruling, which clarified the definition of HRAs and defined the criteria under which HRAs could be used. The IRS clarified that HRAs can reimburse employees for payment of personal health insurance premiums and must be solely funded by the employer.[4]
- **In 2013,** after the passage of the ACA, the IRS issued guidance that "employer payment plans" could not be integrated with individual market coverage and are not compliant with ACA provisions.[5] That year, the tri-agencies also issued guidance stating that employer-funded HRAs used to purchase individual market insurance would constitute a violation by the employer of ACA requirements for group health plans.[6] This guidance was formally incorporated into regulation in 2015.
- **In 2017,** President Trump issued an executive order asking the tri-agencies. to investigate ways to expand the use of HRAs to promote access to insurance coverage.[7]
- **In 2019,** the tri-agencies jointly published a final rule expanding flexibility for the use of HRAs.[8] Specifically, the rule allowed ICHRA funds to be used to reimburse employees and covered dependents for premiums for individual market health insurance or Medicare as well as cost-sharing for services covered by the plan.

In the preamble to the 2019 final rule, the tri-agencies stated that subsidizing the purchase of individual market coverage through ICHRAs may be administratively simpler for employers and allow them to offer enrollees a choice among different types of plans that meets their needs. Some commenters noted ICHRAs may impact individual insurance markets by expanding the risk pool, potentially lowering individual market premiums, noting that the non-discrimination protections in the rule would limit adverse selection.[9]

At the same time, the tri-agencies acknowledged in the final rule some of the concerns raised by other stakeholders. ICHRAs could result in individuals paying higher deductibles and OOP costs. Individuals could move from group health plans to individual market plans with less robust coverage or reduced access to providers. Commenters suggested employers might target certain classes of employees with ICHRA offers to reduce group health plan costs, such

4 IRS. Notice 2002-45 Health Reimbursement Arrangements. Link.
5 IRS Notice 2013-54 Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements. Link.
6 Departments of Labor, Health and Human Services, and Treasury. "FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XI)" January 24, 2013. Link.
7 Federal Register. Executive Order 13813. Promoting Healthcare Choice and Competition Across the United States. October 12, 2018. Link.
8 CMS. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. IRS, EBSA, and HHS. June 20, 2019. Link
9 CMS. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. IRS, EBSA, and HHS. June 20, 2019. Link

as categories of workers that are typically older or lower wage. If ICHRA offers do disproportionately divert employees with greater health needs to the individual market, that could lead to increases in individual market premiums. These commenters expressed concerns that the nondiscrimination guardrails in the rule might be insufficient to avoid this possibility. Commenters also noted that among employees not currently offered coverage, the offer of an ICHRA could cause them to lose access to advance premium tax credits (APTCs).[10]

This paper explores the possible impacts of ICHRA participation by employers and employees by evaluating the possible shift from group health plans to ICHRAs and the number of individuals who will enroll in individual market plans funded by ICHRAs. In addition, Avalere assesses how these shifts could affect the scope of coverage and out-of-pocket costs for individuals newly enrolled in ICHRAs. The possible impact of ICHRAs on individual market risk pools, or the Medicare program, is outside the scope of this analysis.

Estimated ICHRA Participation

Estimating likely total ICHRA enrollment requires evaluation of a set of interacting elements.

1. The number of employers that will offer ICHRAs, and the number of individuals these firms employ, determines the pool of individuals eligible for ICHRA funds they can use to enroll on an individual market plan.
2. Among firms offering ICHRAs, the number of firms that will only offer ICHRAs to specific classes of employees, such as part-time employees, will also determine the total pool of eligible employees. Employers must follow certain non-discrimination rules in defining classes, and a class of employees offered an ICHRA may not also be offered group health plan coverage.
3. Among workers offered ICHRAs, some workers will not enroll in individual market coverage. The number of employees that choose to enroll, including spouses and dependents that enroll, is the final variable in estimating participation.

Avalere explored each of the elements above to determine how many people may be enrolled, or may enroll in the future, in coverage paid for by ICHRAs.

Employer Participation in ICHRAs

In estimating the number of employees likely to participate in ICHRAs, Avalere first identified employer participation. To do this, Avalere relied on private employment estimates by firm size from the Bureau of Labor Statistics and recent KFF estimates of employer ICHRA uptake. These estimates indicate that ICHRAs offered by employers are expected to increase between 2021 and 2023. KFF research also indicates that employers with fewer than 100 employees reported that they are more likely than larger employers to offer ICHRAs in the future.[11]

10 Federal Register. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. Proposed Rule. October 29, 2018. Link.
11 Kaiser Family Foundation. Employer Health Benefits Survey, 2021. Link

According to the KFF survey, the percent of firms "very likely" to offer ICHRAs to employees in the next 1-2 years ranges from 1% for firms of more than 100 workers to 9% for firms of 50-99 workers. Survey findings indicate that ICHRA take-up is currently 3 to 4 times higher among firms with under 100 employees compared to firms with 100 or more employees. Industry-reported estimates are 2 to 3 times higher than what was self-reported by employers in the KFF study. For example, a Willis Towers Watson survey estimates take-up to range between 15% and 20%.[12] Due to the broader survey sample size and methodology used by KFF, Avalere relies on KFF's estimates in its analysis.

ICHRA Offer Rates by Group Health Plan Offer History—Table 1

	Current ICHRA Offer Rates (2021)	Anticipated Offer Rates by 2023
Firms Not Offering Health Benefits	7%	10% *
Firms Offering Health Benefits	4%	7%

KFF 2021 Employer Health Benefits Survey; * KFF reports results among employers with 3 – 199 employees.

ICHRA Offer Rates by Employer Size—Table 2

	Current ICHRA Offer Rates (2021)	Anticipated Offer Rates by 2023
3-49 Workers	4%	7%
50-99 Workers	3%	9%
100+ Workers	1%	1%

KFF 2021 Employer Health Benefits Survey.

Industry sources report early ICHRA adopters are concentrated among the professional services, non-profits/associations, technology, healthcare providers, and services sectors.[13] They also report that many wholesale and retail employers are considering offering ICHRAs as of 2022.[14]

The KFF survey also asked employers, if they intend to offer ICHRAs, which groups of employees they intend to offer ICHRAs to. The survey indicates that among large firms that offer, or intend to offer, ICHRAs, 60% offer, or intend to offer, to low-wage workers in particular. Meanwhile, 44% offer, or intend to offer, ICHRAs to all employees. Additionally, 16% of

12 Willis Towers Watson. 2020 Health Care Delivery Survey. Link
13 TakeCommand. 2020 ICHRA Report.
14 Ibid.

employers offer, or intend to offer, ICHRAs to part-time or seasonal employees.[15] While non-discrimination provisions in the rule seek to protect employees from being targeted based on age, health status, or select other features, the possibility that ICHRA offers may disproportionately be extended to low wage workers has implications for which populations would be most affected by the shift in coverage.

Employee Participation in ICHRAs When Offered

Overall Participation

Once employer offer rates are determined, the number of employees that enroll in coverage using ICHRA funds determines final participation rates. Some employees will decline to enroll in coverage reimbursed by the ICHRA. For firms likely to offer ICHRAs, Avalere estimated how many of these firms' employees would enroll in coverage. The number of employees enrolled in coverage funded by ICHRAs in 2021 was approximately 2 million, and employee enrollment could increase by over 50% in 2022 to 3.1 million. In considering the number of individuals who are newly enrolled in coverage funded by ICHRAs, it is important to distinguish between individuals who shift from group health plans to ICHRA-funded coverage and individuals who were not previously offered a group health plan by their employer.

Employee Participation in ICHRAs (in Thousands) – Table 3

Firm Size (# Employees)	Employers previously offering Health Benefits		Employers not previously offering Health Benefits	
	2021	2022	2021	2022
<100	570	1,148	722	1,039
100+	393	396	359	517
Total	963	1,543	1,081	1,556

KFF 2021 Employer Health Benefits Survey; Bureau of Labor Statistics.

Note: Some values may not sum due to rounding

When considering total enrollment, it is also important to consider potential enrollment by employees' spouses and dependents. Avalere relied on enrollment trends of spouses and dependents in group health coverage to produce estimates of total ICHRA enrollment. However, it is important to consider that employees may behave differently when presented with the option to enroll family members in individual market coverage through an ICHRA, as compared to group health plan coverage. In 2021, 1.8 million people previously enrolled in group health plan coverage, including employees' spouses and dependents, may have been enrolled in ICHRAs. This enrollment number could grow to 2.8 million in 2022.

ICHRA enrollment among employees, as well as their spouses and dependents, at firms that previously did not offer health coverage could reach 2.9 million individuals in 2022. For

15 Kaiser Family Foundation. Employer Health Benefits Survey, 2021. Link

employers who did not previously offer health coverage but now offer an ICHRA, it is not possible to determine prior coverage status and source of coverage. These individuals could have been enrolled in individual market coverage and eligible for APTCs, enrolled in coverage through their spouse or parent, or uninsured. Prior source of coverage or uninsured status could influence an individual's decision to enroll in an individual market health plan funded by an ICHRA when offered. Across employer types, regardless of health coverage offer history, ICHRA enrollment could reach 5.7 million under a high enrollment scenario that includes spouses and dependents.

Part-Time Employee Uptake

The 2019 rule allows employers to selectively offer ICHRAs to defined classes of employees, permitted the employer meets certain requirements. Among the 8 employee classes defined in the rule, part-time workers represent a significant share of those who are likely to newly gain employer funded coverage through an ICHRA. Avalere estimates that approximately 288,000 part-time employees participated in an ICHRA in 2021. In 2022, part-time employee participation could reach 415,000. There are unique implications for part-time employees when considering whether individual market premiums are lower for those individuals with or without an ICHRA, which are explored below.

Comparison of Plan Costs

This analysis also explores some differences in coverage and cost that employees would experience if employers began offering ICHRAs. To do this, Avalere compared group health plan premiums and ACA individual market coverage premiums that ICHRAs would contribute to, as well as OOP costs for both types of plans. This examination focuses on comparing group health plans to silver and gold individual market plans, as these plans tend to have the most similar actuarial value (AV) to group health plans. However, individuals may ultimately use their ICHRA funds to purchase bronze plans, not fully aware that bronze plans have a lower AV than most group health plans.

Premium Costs

On average, group health plans have slightly higher premiums, $645 a month compared to $436 for a silver exchange plan. However, comparisons between group health plan premiums and ACA individual market premiums must also take into account the impact of age rating on individual market premiums. For example, on the exchange the average silver plan premium is $342 a month for a 21 year old individual and $708 a month for a 55 year old individual.[16] Enrollees on a specific group health plan have the same premium regardless of their ages. In the individual market, older individuals pay higher premiums within parameters set in the ACA. Amongst employees offered ICHRAs, individual market premiums will be higher for an older employee than their younger colleague, potentially creating a disparity for the older workers

16 Kaiser Family Foundation. Health Insurance Marketplace Calculator. 2022. Link,

offered ICHRAs. If employers fully fund ICHRAs and adjust funding amounts to account for age, this issue could be mitigated. To the extent an ICHRA doesn't cover all premium costs, an individual would have to pay the difference with after-tax dollars unless the employer pairs the ICHRA with a cafeteria plan to allow use of pre-tax dollars for premiums.

For low income individuals already enrolled on an exchange, an ICHRA offer could cause them to lose access to APTCs and cost sharing reductions (CSRs), resulting in increased premiums and OOP costs. To qualify for APTCs, an individual cannot have access to "affordable coverage." When an ICHRA funds individual market coverage at a level that is considered "affordable," an employee is disqualified from receiving APTCs. Coverage under an ICHRA is considered "affordable coverage" if the monthly premium of the lowest cost silver plan available to the applicant on the exchange for self-only coverage costs less than 9.61% of the employee's yearly household income.

Based on this affordability test, some individuals may find the amount of the exchange premium they pay is higher on an ICHRA than when they are eligible for APTCs. The amount of employer ICHRA funding, the employee's household size and income, and the cost of plans on the exchange all contribute to whether an employee pays lower premiums on the exchange with an ICHRA or without. It can be difficult for an employer to evaluate whether offering an ICHRA could cause employees' exchange premiums to go up, largely because they may not know the employee's household size or total household income. When an ICHRA causes an employee's exchange premiums to increase, the employee may forgo coverage entirely due to the higher premiums.

Offering part-time employees ICHRAs for the first time will also have implications for their coverage and healthcare costs. While part-time employees typically do not receive employer-sponsored coverage, an ICHRA offer may not necessarily result in improved coverage.[17] Although many part-time workers may receive coverage through a spouse, have Medicaid, or be uninsured, a large number may receive their insurance through the ACA individual market and, thus, qualify for APTCs based on their income. Those on ACA individual market coverage may also qualify for cost-sharing reductions (CSRs) that lower their deductibles and other exchange plan cost sharing.

Deductibles

Deductibles tend to be higher for exchange plans than for group health coverage. This leads to enrollees in individual market plans spending more to meet their deductible before their plans begin to pay for services and prescription drugs compared to those in group health plans. While relatively young people may have a lower total premium on an exchange plan, people of all ages may face higher deductibles when moving from a group health plan to the individual market.

17 Carroll, W.A. and Miller, G.E. *Differences in Health Insurance Coverage between Part-Time and Full-Time Private-Sector Workers, 2005 and 2015.* Statistical Brief #511. April 2018. Agency for Healthcare Research and Quality, Rockville, MD

Average Premiums and Deductibles by Coverage Type—Table 4

Plan Type	Average Premium	Average Deductible
Group Health Plan Employee Only Coverage*	$645	$1,434
Exchange Bronze for an Individual	$328	$6,094
Exchange Silver for an Individual	$436	$4,500
Exchange Gold for an Individual	$482	$1,458

* KFF analysis of healthcare.gov data, KFF Employer Health Benefits Survey 2021

KFF Average Marketplace Premiums by Metal Tier, 2018-2022

HealthCare.gov Marketplaces 2021 Open Enrollment Report

Considering average premiums alone when considering total plan costs for enrollees may omit some potential costs, as premiums vary by age, and individuals' healthcare utilization patterns can vary due to a range of factors. Ultimately, features such as deductibles, OOP limits, and cost-sharing structures play important roles in determining total costs.

Out-of-Pocket Limits

Full-time employees who enroll in individual market coverage funded by an ICHRA are likely to find that there are differences in their OOP costs that go beyond the deductible. In addition to the differences in deductibles noted above, the average maximum OOP limit for silver tier individual market plans ($5,725) is higher than the average limit for group health plans ($4,416).[18,19] A plan's out-of-pocket limit is a key factor in determining a beneficiary's potential maximum liability in a given year, and differences between group health plans and individual market plans are significant.

Individuals with significant healthcare needs are more likely to reach their OOP limit than individuals who rarely use healthcare. For example, a 2015 study found that out-of-pocket expenses for medications in a typical silver plan are twice as high as they are in the average group health plan for individuals with chronic conditions.[20] When considering the differences between group health plans and individual market coverage funded by ICHRAs, the OOP limit can be reasonably expected to impact individuals who use healthcare to a greater degree than people who rarely use healthcare.

Potential Risk Shifts Impact on Costs

Enrollment shifts to ICHRAs, premiums, and OOP costs may vary for different workers based on factors such as part-time status, income level, geographic location, age, or health status. For example, employers targeting a class of employees that may be "higher risk" for ICHRA offers

18 Thorpe, et al. (2015). "Out-Of-Pocket Prescription Costs Under A Typical Silver Plan Are Twice As High As They Are In The Average Employer Plan." Health Affairs. Link

19 Urban Institute. Many People with Employer-Sponsored Insurance Face High Out-of-Pocket Costs for COVID-19. Link.

20 Thorpe, et al. (2015). "Out-Of-Pocket Prescription Costs Under A Typical Silver Plan Are Twice As High As They Are In The Average Employer Plan." Health Affairs. Link

could adversely impact the individual market risk pool. In the KFF Employer Health Benefits Survey, among large employers, 44% of respondents stated that they offer or intend to offer ICHRAs to all employees, while 60% of respondents offer or intend to offer to low-wage workers. This indicates that certain employees could be targeted, and adverse selection could occur. However, if a large number of individuals who rarely use health care purchase coverage using ICHRA funds, the expansion of individual market risk pools could reduce premiums. Impacts on the individual market could vary by state, with positive impacts in some states and negative impacts in others. Ultimately, any shifts in risk pools resulting from ICHRA participation will have implications for enrollees in the broader individual market, beyond those enrolled in ICHRAs.

Comparison of Plan Features

In addition to cost, plan features such as provider networks, care management programs, and wellness tools can influence the quality of coverage and the outcomes experienced by enrollees. This segment of the analysis examines provider network breadth, care management tools, and wellness tools offered through group plans to explore possible differences in the care people can access in group health plans versus individual market plans.

Provider Networks

In addition to enrollee costs, health plans in the individual market may use network design to offer lower premiums.[21,22] Individuals who shift from group health plans to ICHRAs are likely to have access to fewer providers. A comparison of primary care physicians' participation in exchange plans to that in group health plans showed that in-network participation was 9 percentage points lower in the exchange plans. State-by-state analysis shows wide variation in the degree of difference in network breadth, ranging from 4.1 percentage points in Massachusetts to 20.4 percentage points in Texas.[23] Thus, narrower individual market provider networks might impact employees to different degrees based on where they live.

Avalere analysis found that over 70% of plans on the exchanges were comprised of plan types with more restrictive networks, including health maintenance organizations and exclusive provider organizations. Only 27% of plans were preferred provider organizations, or point of service plans, which typically cover care with a broader network.[24] The analysis also found that, compared with group health plans, exchange plans had networks with 42% fewer cancer and cardiac specialists, 32% fewer mental health and primary care doctors, and 24% fewer hospitals.[25] Individuals with greater healthcare needs or who have complex conditions requiring specialist care may be most sensitive to the contraction of their provider network.

21 Polsky, et al. (2016) “Marketplace Plans With Narrow Physician Networks Feature Lower Monthly Premiums Than Plans With Larger Networks” Health Affairs. Link
22 Polsky and Weiner (2015) “The Skinny on Narrow Networks in Health Insurance Marketplace Plans.” RWJF. Link
23 Polsky, et al. “Scope Of Primary Care Physicians’ Participation In The Health Insurance Marketplaces” Health Affairs. August 2018. Available here.
24 Avalere Health. Plans with More Restrictive Networks Comprise 73% of Exchange Market. 2017. Link.
25 Ibid.

Care Management and Wellness Tools

Employers also have various tools at their disposal, often bundled with the plans they purchase in the group market, to deliver quality and improve health outcomes among employees. These options range from value-based plan designs to wellness programs to patient engagement tools to onsite clinics. According to an industry survey, as much as 35% percent of employers may be directly contracting with accountable care organizations (ACOs) or high-performance networks (HPNs).[26] These models, under which an entity is responsible for patients' outcomes and total cost of care, can promote better quality care delivery.

Many group health plans also bundle wellness programs into their offerings to help employers support improved outcomes. According to the KFF Employer Survey, 58% of small firms and 83% of large firms offer a program in at least one of the following areas: smoking cessation, weight management, and behavioral or lifestyle coaching.[27] Many employers are also incorporating individualized digital health tools that help improve care into their group health plans.

These employer tools work best when group health plan data can be leveraged by the employer's vendors to inform the employer about which quality or health promotion initiatives are most relevant to their employees and which individuals are most likely to benefit from specific initiatives. When employees enroll on individual market coverage through an ICHRA, employers do not have the insight claims data provides to inform other initiatives to promote employee health and well-being. These tools and wellness programs can impact employees' overall healthcare costs and outcomes, and there are differences in the availability of these programs and the potential impact of the programs when comparing group health plan coverage to individual market coverage.

Conclusion

Over 3 million employees may be enrolled in ICHRAs in 2022, with about half of these individuals losing coverage under a group health plan. There are substantial differences between the coverage an individual would receive from a group health plan as compared to coverage available in the individual market through an ICHRA. Key considerations when assessing these differences include changes to the premium paid by individuals, OOP costs, and provider access. Individual market plans funded by ICHRAs may also lack some of the quality improvement and health promotion features commonly included with group health coverage.

Employees and dependents shifting into individual market plans funded by an ICHRA from group health plans are likely to move to plans with higher deductibles and OOP costs. Individual

26 Business Group on Health. "2021 Plan Design Survey." Link.
27 Kaiser Family Foundation. "2021 Employer Health Benefits Survey." Link.

market plans are also likely to have more limited provider networks than group health plans. Shifts to ICHRAs may differentially impact workers based on factors such as part-time status, income level, geographic location, age or health status. Targeting of certain workers could also adversely impact individual market risk pools, which would place upward pressure on premium costs. Conversely, if the non-discrimination provisions in the rule prevent such targeting, expansion of enrollment in the individual market could support individual market risk pools. Ultimately, these complex interactions have multiple implications for enrollee costs.

Methodology

The number of employees participating in an ICHRA is a function of the number of employees offered ICHRAs who were previously offered group health plans by firm size, and the take-up rate of ICHRAs if offered. To develop its estimates on employer offer rates, Avalere used employment statistics by firm size from the Bureau of Labor Statistics (BLS),[28] employer offer rates of group health plans by firm size from the BLS National Compensation Survey,[29] and self-reported offer rates of ICHRAs by firm size from the KFF Employer Health Benefits in the US (2021).[30] Avalere assumes that the reported offer rates of ICHRAs among employers with 3 to 199 employees not previously offering group health plans applies to all firm sizes. Employee take-up rate of ICHRAs is based on industry reported data in a 2020 ICHRA report by TakeCommand.[31] Estimates of the number of spouses or dependents covered by ICHRAs was derived from the Medical Expenditure Panel Survey (MEPS) estimates of plan type selection.[32] Avalere assumed similar coverage of spouses and dependents as with group health plan coverage.

Avalere took a similar approach to estimate the number of part-time employees not previously offered ESI that would enroll in an individual market plan funded by an ICHRAs. Avalere used employment statistics by firm size and part-time status from BLS to identify the number of part-time employees at large firms.[33,34] To identify the number of part time employees offered ICHRAs, Avalere first estimated the number of part-time employees without previous access to group health plans using the BLS National Compensation Survey.[35] Then, Avalere multiplied that number by the proportion of large employers self-reporting that they currently offer or intend to offer ICHRAs to all employees or only part-time employees from the KFF Employer Health Benefits Survey.[36] Finally, Avalere applied the employee take-up rate of ICHRAs reported in the 2020 ICHRA report by TakeCommand to derive our final estimates of part-time employee participation.

28 Bureau of Labor Statistics. Distribution of private sector employment by firm size class (Q1). Link
29 Bureau of Labor Statistics. National Compensation Survey: Employee Benefits in the United States, March 2021. Link
30 Kaiser Family Foundation. Employer Health Benefits Survey, 2021. Link
31 TakeCommand. 2020 ICHRA Report. Link
32 Medical Expenditure Panel Survey. Percent of private-sector employees enrolled in a health insurance plan by firm size and selected characteristics: United States, 2020. Tables I.C.4, I.D.4 and I.E.4. Link
33 Bureau of Labor Statistics. Distribution of private sector employment by firm size class (Q1). Link
34 Bureau of Labor Statistics. Employed persons by class of worker and part-time status. Link
35 Bureau of Labor Statistics. National Compensation Survey: Employee Benefits in the United States, March 2021. Link
36 Kaiser Family Foundation. Employer Health Benefits Survey, 2021. Link

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