The strategic potential of ICHRAs by employer characteristics

Healthcare costs continue to rise year after year, placing increasing pressure on employers who sponsor group plans for their active employees.[1] The Individual Coverage Health Reimbursement Arrangement (ICHRA) is gaining traction as a potential alternative.[2] ICHRA funds help employees pay for individual health insurance premiums and eligible expenses, giving them flexibility to choose from a wide range of plans while enabling employers to move away from traditional group plans. Administration then shifts from the employer to an ICHRA administrator.

An effective healthcare strategy strikes a balance between cost savings, regulatory compliance and employee satisfaction. For smaller employers without the resources to manage a group plan, ICHRAs can provide a practical alternative. To evaluate the impact of an ICHRA strategy on medium to large employers, we used Alight's proprietary modeling tool to compare projected costs under traditional group plans versus an ICHRA approach.

Alight Case Study

This case study examines a company with 1,050 employees nationwide — 40% based in California — that currently offers two self-funded group health plans and a fully insured health plan for eligible employees in Southern California. In 2026, the company expects to spend $18.5 million subsidizing employee medical premiums.

Our analysis explores strategies to reduce the employer subsidy by 5% (approximately $0.9 million in savings). We then assess the financial impact on employees by comparing premiums and out-of-pocket (OOP) costs under the current group plan structure versus the most cost-effective options available through an ICHRA approach.

ICHRAs are primarily used to purchase health plan coverage on the Affordable Care Act (ACA)'s Individual and Family Marketplace (IFM).[3] In 2026, IFM enrollees could choose from an average of 17 bronze, 18 silver, 15 gold and two platinum plans offered by an average of four carriers.[4]

Unlike "one-size-fits-all" group plans, IFM plan options and premiums vary by location — and often by age — making it challenging to determine appropriate ICHRA contribution amounts. The two approaches below highlight the trade-off between delivering a positive employee experience and managing administrative complexity.

— **Uniform ICHRA –** Each covered member (employee, spouse, child) receives the same ICHRA amount. This approach is the simplest to administer. However, it results in the lowest percentage of members experiencing cost reductions and creates significant disparities based on location and age. Some employees receive enough to fully cover premiums with allowance left over to pay out-of-pocket costs, while others could spend nearly 10% of their salary on premiums alone.

— **Calibrated ICHRA –** The ICHRA amount provided to each covered member varies by allowable IFM rating criteria.[5] While more complex to manage, this approach delivers a higher percentage of employees with lower costs. It also reduces disparities, minimizing both overfunding and underfunding across the employee population.

— **Hybrid approaches –** Employers can also choose an approach that falls between these two bookends, balancing incremental improvements in equity and savings with manageable complexity.

Comparison methodology

Below, we compare total premium and OOP costs under an IFM plan and ICHRA subsidy versus the same costs under the current group plan design and subsidy. We assume each employee selects the most cost-effective IFM plan based on low, moderate or high healthcare needs. Additional details are provided in the assumptions, methods and definitions section at the end of this paper.

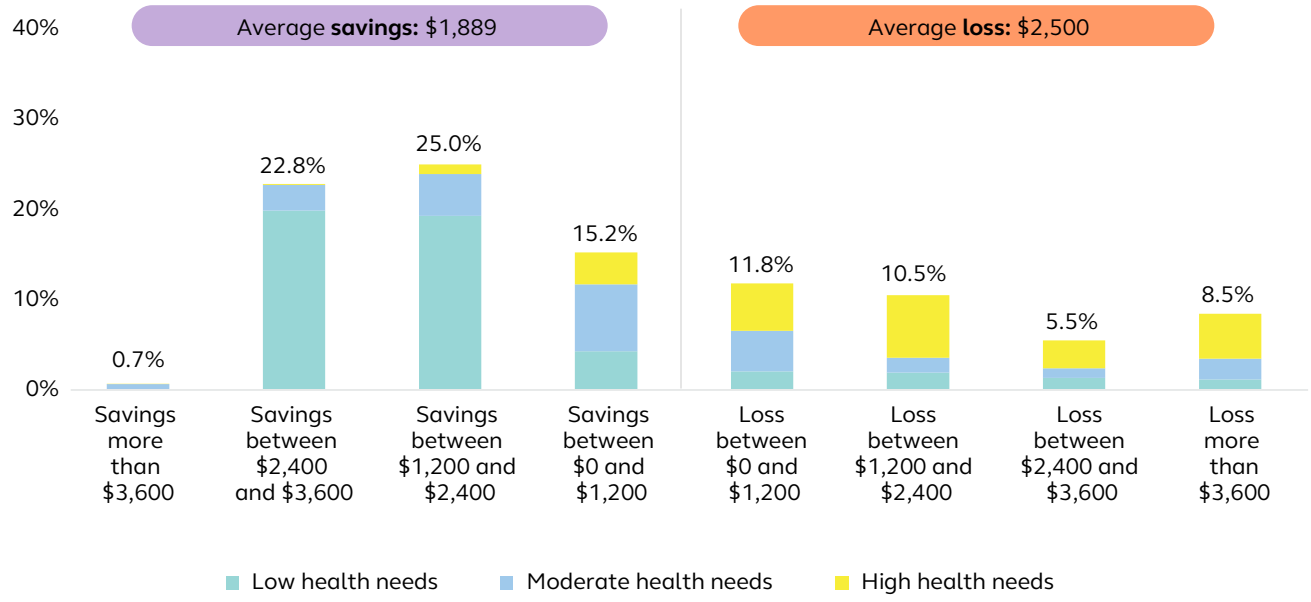
Change in member healthcare cost using ICHRA compared to the group plan

Alternatives	Percentage of members with savings	Average member savings	Percentage of members with losses	Average member loss
Uniform	64%	$1,889	36%	$2,500
Calibrated	70%	$1,910	30%	$1,447

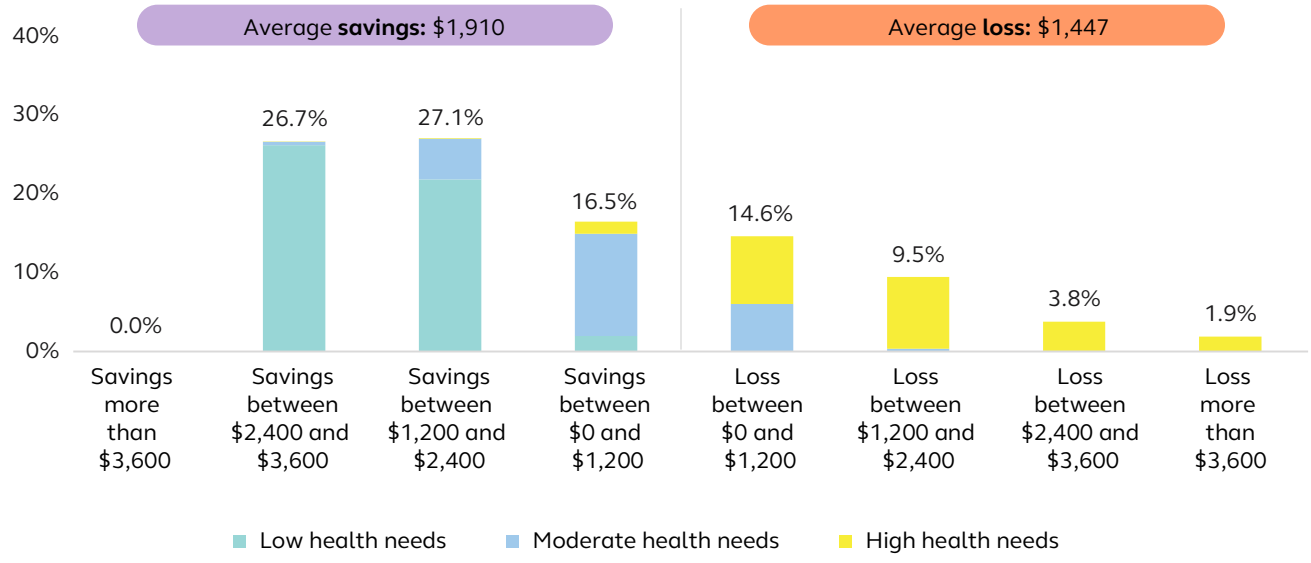
The calibrated approach cuts the average loss of the uniform approach by over 40%, delivering a more equitable program without increasing the employer's subsidy cost.

The bar charts below detail that members with higher healthcare needs have greater losses on the IFM, where high OOP maximums are common. In the calibrated approach, almost all members with low to moderate health status will find savings on the IFM, while most members with high healthcare needs will experience losses. With the uniform ICHRA, even members with lower healthcare needs can have losses if they live in a high-cost area or are older.

Change in member healthcare cost
Uniform ICHRA and 5% employer subsidy reduction



Change in member healthcare cost
Calibrated ICHRA and 5% employer subsidy reduction



ICHRA success will vary based on employer characteristics

Employers with **geographically concentrated populations** require fewer location-based adjustments, reducing complexity and promoting equity within their workforce. They can offer ICHRAs to localized groups while maintaining group plans for other segments of their workforce, subject to regulatory requirements.

For **lower-paid populations**, the ACA affordability thresholds are more difficult to meet,[6] potentially requiring higher ICHRA amounts and creating cost volatility when IFM premiums fluctuate. Additionally, IFM premiums are not published until late October, making affordability testing more challenging.

Employers with **fewer than 50 full-time employees** are exempt from ACA affordability mandates.[6] Even modest ICHRA offerings can be valuable for recruitment and retention.

Employee experience when transitioning to the IFM will vary greatly based on the **current group health plan.** Employers offering group plans with either lower premiums or richer designs than the IFM may face greater disruption.

Employers concerned about **high-cost claims** can use ICHRAs to move employees to the IFM, improving financial predictability and eliminating large claims risk.

Employers must consider whether the IFM's more limited networks, stricter formularies and higher cost-sharing align with their **recruitment and retention goals.**

Since the IFM **varies by location**, opportunity will differ depending on the locations where employees live and work.

Conclusion

The employer in this case study saved $0.9 million and eliminated high-cost claims risk while providing most employees with access to lower-cost coverage. However, not all employers will find the same financial opportunity. In addition, employees will likely be subject to narrower networks, tighter formularies and higher cost-sharing relative to their current group plan.

The viability of the ICHRA strategy for any employer will depend on their workforce demographics, employee locations, current group program and financial and human resource objectives. **Alight is available to support this evaluation and guide decision-making.**

Assumptions, methods and definitions

— This client case study compares the 2026 plan costs of a medium-sized company to the 2026 IFM, using Alight's comprehensive database of all plan designs and tobacco-free premiums available on the IFM. The analysis incorporates each member's actual age, location, coverage tier, current group plan contribution and current group plan design, ignoring tobacco or wellness credits.

— Affordability is assessed based solely on premium costs. However, member healthcare cost in this analysis includes both premiums and OOP expenses, such as copays, deductibles and coinsurance. OOP costs are estimated by inputting actual 2026 plan designs from both the group plans and the IFM into Alight's modeling tools, along with healthcare utilization data from the Merative Marketscan database.

— Employers with 50 or more full-time employees must offer coverage that complies with ACA affordability standards or face penalties. If an ICHRA is affordable, the employee becomes ineligible for federal premium tax credits. If an ICHRA is unaffordable and the employee chooses federally subsidized coverage on the ACA marketplace, the employer will incur a penalty.[6] An ICHRA is considered affordable if the employee's share of the premium for the lowest-cost silver plan (after the ICHRA subsidy) does not exceed 9.96% of household income in 2026.[7]

— This analysis assumes dependent coverage is subsidized at the same rate as employee coverage. Employers could create greater savings by providing a lower subsidy for dependents.

— The Calibrated ICHRA approach creates geographic and funding bands to determine ICHRA allocations. Geographic band categorizations are determined by comparing the lowest premium gold plan available in a member's location to the average lowest premium gold plan across the company's population. Funding band categorizations are determined based on the IFM's location-specific age curves.

— Both alternatives in this case study comply with all regulatory requirements, including variations by "approved" employee classes, variations by age and compliance with ACA affordability and minimum value requirements.[3,6,7] Please feel free to contact Alight for more detail.

[1] Aon: U.S. Employer Health Care Costs Expected to Rise 9.5 Percent in 2026 (Sept. 10, 2025). Accessible at: **https://aon.mediaroom.com/2025-09-10-Aon-U-S-Employer-Health-Care-Costs-Expected-to-Rise-9-5-Percent-in-2026** (last accessed 3/11/2026)

[2] Growth Trends for ICHRA & QSEHRA 2024-2025 (June 17, 2025). Accessible at: **https://www.hracouncil.org/report** (last accessed 3/11/2026)

[3] Health Reimbursement Arrangements and Other Account-Based Group Health Plans, Final Regulations, 83 FR 54420 (Oct. 29, 2018). Accessible at: **https://www.govinfo.gov/content/pkg/FR-2018-10-29/pdf/2018-23183.pdf** (last accessed 10/8/2025)

[4] Alight's Analysis of the Ideon Database, Alight Retiree Health Solutions Actuarial Team, Internal Analysis (on file with Alight) (Mar. 3, 2026)

[5] Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 CFR 147 (as amended through Feb. 27, 2026). Accessible at: **https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147** (last accessed 3/19/2026)

[6] Shared Responsibility for Employers Regarding Health Coverage, Final Regulations, 79 FR 8544 (Feb. 12, 2014). Accessible at: **https:// www.federalregister.gov/documents/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage (last accessed 10/8/2025)**

[7] Rev. Proc. 2025-25 (Oct. 8, 2025). Accessible at: **https://www.irs.gov/pub/irs-drop/rp-25-25.pdf** (last accessed 3/10/2026)

Contact information

Kate Troutman, FSA, MAAA
Senior Manager and Retiree Medical Actuary, Retiree Health Solutions
kate.troutman@alight.com

Dr. Elizabeth Kochneff, FSA, MAAA
Senior Director and Retiree Medical Actuary, Retiree Health Solutions
elizabeth.kochneff@alight.com