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Affordable Health Insurance Options for Small Business and Low-Wage Workers Remains Elusive: Experience With New Health Reimbursement Arrangements in New Jersey

Joel C. Cantor, ScD[1], Jolene Chou, MPH[1], Margaret Koller, MS[1], and Katherine Hempstead, PhD[2]

Abstract

Low-wage workers and those employed by small businesses are least likely to be offered health insurance coverage and they are over-represented among the uninsured. Two new forms of health reimbursement arrangements (HRAs) that allow employers to help fund individual market coverage for workers have been touted as breakthrough strategies to help fill this gap. Despite several years of experience and low adoption, little is known about employer understanding of or views about these HRA options. Consistent with other evidence, only 11.8% of New Jersey employers we surveyed offer or plan to offer either of the HRA options. Few respondents (18.5%) report familiarity with either option. Even among businesses that offer or plan to offer this form of HRA, under half (47.6%) say that they are familiar with them. Other reasons cited for not offering these options include broker advice and complexity. While more investigation is needed, these findings suggest that new strategies should be explored to fill the gap in health insurance for low-wage and small business employees.

Keywords

health reimbursement arrangements (HRAs), individual health insurance, employer-sponsored health insurance, small businesses, uninsured

What do we already know about this topic?

The share of small and low-wage firms offering employer-sponsored health insurance in the U.S. has declined for over a decade, and workers for such firms are over-represented among the uninsured.

How does this research contribute?

We conducted a survey of New Jersey businesses to assess experiences with 2 new forms of health reimbursement arrangements (HRAs) that were developed to narrow the gap in coverage for workers in small and low-wage firms by allowing employers to help pay for individual market health insurance.

What are your research's implications toward theory, practice, or policy?

Lack of awareness, plan complexity, and broker advice may dampen adoption of these new forms of HRAs. Unless these dynamics change, new policy strategies will be needed to fill the coverage gap for low-wage and small business employees.

Introduction

The share of small and low-wage firms offering employer-sponsored health insurance has declined for over a decade, and workers for such firms are over-represented among the uninsured.[1] Two relatively new health reimbursement arrangements (HRAs) were developed to narrow this gap by allowing employers to help pay for individual market health insurance. Despite low adoption, little is known about employer understanding of or views about these options.

Many types of HRAs are available, most using pre-tax dollars to cover out-of-pocket expenses for employees with high-deductible plans. The 2 new HRA authorities allow employers to offset individual market premiums.

Authorized in 2016 under the 21st Century Cures Act, Qualified Small-Employer HRAs (QSEHRAs) allow non-taxed contributions to individual premiums, including in ACA marketplaces. In June 2019, Individual Coverage HRAs (ICHRAs) were established in regulations permitting employers to contribute to individual premiums, again including in ACA marketplaces.[2]

QSEHRAs have more restrictions than ICHRAs in that they generally must be offered to all employees, contributions are capped, and they are limited to small firms (≤50 workers). ICHRAs contributions are not capped and may be offered to specific employee classes (eg, part-time, retired). Whereas QSEHRAs may be combined with ACA premium tax credits, ICHRAs may not. The HRA options allow employers to contribute to individual market premiums, a strategy heralded as having potential to create viable coverage options where employer-sponsored insurance does not.

A recent report from an HRA association suggests that uptake of these plans has been low,[3] but little is known about reasons so few employers have adopted them or the experiences of those who have. Employer offerings must be reported to the IRS, but these data will not be reported until 2024. These statistics will clarify patterns of adoption but are unlikely to shed light on reasons for low uptake or experiences of adopters. This article provides insights into employer understanding and views about ICHRAs and QSEHRAs drawing on a survey of New Jersey businesses.

Methods

An anonymous online survey of a convenience sample of New Jersey employers was conducted in May 2022 to gage HRA experiences. Two business associations distributed the survey (N ≈ 6800) via e-mail followed by 2 reminders over 3 weeks. A total of N = 178 eligible employers responded, including N = 97 (54.4%) with fewer than 50 workers. The study was reviewed and approved by the Rutgers University Institutional Review Board. Our survey instrument (see Online Appendix) asked about familiarity with the options, whether firms offer or are likely to offer them in the next 2 years, and reasons for not offering. Questions about firm and employee characteristics were adapted from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

Limitations

Our study is limited to New Jersey, has a low response rate, and uses a convenience sample, limiting generalizability. Nevertheless, given the paucity of available research, our findings provide a valuable early assessment of these HRAs.

Study Results

Respondents included human resource professionals (36.5%), owners (21.9%), company officers (12.4%), and those in other roles (29.2%). Responses have a geographic distribution similar to the state population.[4] Compared to the 2021 MEPS-IC (Online Appendix Table A1), our sample under-represents very small (<10 workers), professional services, and retail firms; and over-represents firms with mostly full-time workers, those offering health insurance, and goods producing firms.

Only 11.8% of respondents offer or say they are likely to offer an HRA in the next 2 years (Table 1), with similar adoption rates by HRA type. Among 9 firms currently offering ICHRAs, only 2 offered them to all employees. Among firms currently offering either option (n = 11), employee take-up rates varied from none to 80%. The bottom panel of Table 1 shows that only 18.5% of respondents report that they are very or somewhat familiar with either option, with a similar pattern by HRA type. Even among firms offering or likely to offer an HRA, under half (47.6%) say they are familiar with either option. Offering and familiarity are most common among goods producing and professional services firms (Online Appendix Table A2). Firms with lower wage workforces, without part-time workers, and not offering group health insurance are less likely to offer or be familiar with the HRA options. However, these differences are mostly not statistically significant.

Among the 93.8% of employers not offering an HRA, about half report that they did not know enough about them (Online Appendix Figure A1). Fewer than one in 4 respondents cite broker advice, administrative complexity, or lack of employer or employee interest as reasons for not offering. Small and low-wage firms are less likely to cite lack of knowledge, complexity, and judgment about whether they are good for employees, but more likely to report broker advice and lack of employee interest as reasons for not offering, although most of these differences are not statistically significant (Online Appendix Table A3).

[1]Rutgers University, New Brunswick, NJ, USA
[2]Robert Wood Johnson Foundation, Princeton, NJ, USA

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Corresponding Author:
Joel C. Cantor, Center for State Health Policy, Rutgers University, 112 Paterson St., 5th flr, New Brunswick, NJ 08901, USA.
Email: jcantor@ifh.rutgers.edu

Table 1. ICHRA and QSEHRA Offer and Familiarity.

	ICHRA (n = 178)	QSEHRA (n = 97)[a]	Either HRA (n = 178)
	Percentage Distribution		
Offer			
Currently or likely	9.6	9.3	11.8
Unlikely or somewhat unlikely	31.5	29.9	30.3
Don't know or no response	59.0	60.8	57.9
	Percent Very or Somewhat Familiar		
Familiarity			
All respondents	15.7*	11.3**	18.5**
Currently or likely	35.3	40.0	47.6
Unlikely or somewhat unlikely or no response	13.7	8.1	14.6

[a]Business with <50 employees.
Significant at *$P \leq .10$ or **$P \leq .001$ in based on Fisher's exact or Pearson's Chi-square test.

Conclusion

ICHRAs and QSEHRAs enabling employers to help pay for individual coverage have been advanced to improve worker coverage. Supporters of these options predicted that they would prove to be transformative, as "defined contribution" retirement plans largely replaced "defined benefit" pensions. Some benefits professionals, in particular, argued for these options,[5] while business and labor stakeholders expressed concerns about potential for erosion of employer-sponsored benefits.[6] When first introduced, the Treasury Department predicted that 800 000 employers and 11 million employees would opt for ICHRAs within 5 years.[2]

Our survey of New Jersey employers finds de minimis adoption of these HRA models, consistent with data from an association of HRA administrators.[3] Many factors may be responsible for limited adoption, including growing availability of lightly regulated employer-sponsored plans, enhanced ACA premium tax credits under the American Rescue Plan Act, and employer concerns about a possible recession. Our study also suggests that lack of awareness, plan complexity, and broker advice may also dampen adoption. Unless these dynamics change, new strategies may be needed to fill the coverage gap for low-wage and small business employees.

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Ethics Statement

This study was reviewed and approved by the Rutgers University Institutional Review Board (IRB Study ID Pro2022000189). Participants were administered written informed consent.

ORCID iD

Joel C. Cantor https://orcid.org/0000-0003-0786-3258

Supplemental Material

Supplemental material for this article is available online.

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