The Role of Individual Coverage Health Reimbursement Arrangements—The Liger of Health Insurance?

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In the menagerie of the US health insurance system, several creatures predominate—Medicare, Medicaid, employer-sponsored insurance, and individual private insurance (including Affordable Care Act Marketplace health plans). In 2019, a new hybrid emerged: the individual coverage health reimbursement arrangement (ICHRA or HRA for short).

Individual HRAs are a blend of employer coverage and individual coverage. The funding is similar to employer-sponsored insurance (a mix of employer pretax contributions and the employee's share of premiums), but the coverage itself is an individual insurance plan selected by the employee, including but not limited to Marketplace plans. In short, an employer pays some or all of an employee's premiums for individual coverage. Thus, in the insurance menagerie, individual HRAs are something like a liger—half lion, half tiger.

Similar to ligers, HRAs are real but relatively rare. Individual HRAs first became available in 2020 after the Trump administration created them, building on the Qualified Small Employer Health Reimbursement Arrangements that have existed since 2017. Data on the prevalence of HRAs are limited and of lower quality than for other insurance types, which are measured with federal household surveys, government administrative data, or both.

HealthSherpa, a large insurance broker, reported enrolling 15,000 people in Marketplace HRAs in 2022. Based on this enrollment figure and the company's overall market share, the company's CEO estimated that between 100,000 and 200,000 people nationally were enrolled in individual HRAs in 2022, with the majority in non-Marketplace plans. This compares with more than 14.5 million people in Marketplace plans in 2022 (which has increased to 21 million in 2024), and more than 170 million people with employer-sponsored insurance in 2022.

Meanwhile, a survey conducted by the HRA Council, which is a trade organization, found that the number of employers offering HRA plans has increased dramatically since 2020. Although the respondents were a convenience sample of organizations participating in the HRA Council, thus limiting generalizability, some interesting patterns emerged. Smaller employers, especially those with 5 or fewer employees, are disproportionately likely to offer HRAs, and younger workers are enrolled in HRA-funded Marketplace plans more often than older workers.

More rigorous data come from the 2023 KFF Employer Health Benefits Survey that found 8% of all firms offering employer-sponsored insurance also offered an HRA or something similar, though this number was just 3% for firms with more than 100 workers. A slightly larger share reported they may consider offering HRAs in the future. Among small firms not offering employer-sponsored insurance, 12% offered an HRA or other funds to purchase individual insurance in 2023. Even though this represented an increase from 7% in 2021, it was still below the 16% that offered funds for individual coverage to workers in 2016 before individual HRAs became available.

What should we make of this incomplete portrait of HRAs? For now, HRAs occupy a small niche in the US, though potentially a growing one. A more important concern regards how common HRAs should be vs how common HRAs are. And how should policymakers view individual HRAs?

Because ligers combine features of 2 well-known predators, they inevitably prompt a comparison of which big cat they more closely resemble. Similarly, to understand the pros and cons of HRAs, we need to consider which elements they draw from employer-sponsored insurance and which from individual coverage. What matters more is how the coverage is paid for (including who...
has access to it) and how medical care is reimbursed (benefits, networks, and cost sharing). In other words, in valuing HRAs, we need to know what coverage is being obtained and what is it replacing.

The main potential advantage of the HRA model is that it may offer employers and employees more flexibility. Employers can set a fixed dollar amount instead of having to shop for and purchase insurance. This may induce some small employers to participate who might otherwise not offer health benefits, or who would feel the need to cut benefits in times of rapid premium growth.4 Health reimbursement arrangements may also enable firms with remote workers across state lines to offer meaningful health benefits because employees can use HRAs to obtain coverage wherever they live. In addition, an HRA gives employees many more plan options than they would typically get, especially from small employers.

Key to the value of HRAs is the generosity of the coverage they lead people to obtain. Some employees may have a generalized notion that employer-sponsored insurance is the best kind of private insurance, and that Marketplace or HRA-funded insurance is skimpier, with high deductibles or restricted clinician networks. If that is the case, a shift to HRA coverage could have negative effects for many individuals, particularly those with chronic conditions. However, this notion is belied by the stark differences in cost sharing between Marketplace plans with cost-sharing reductions and those without. For individuals with incomes below 250% of the federal poverty level who sign up for qualifying silver plans with cost-sharing reductions, the average deductible in 2021 was roughly $500 or less (depending on plan type), whereas deductibles in employer-sponsored plans averaged $1200 at large firms and $2000 at small firms.5 Thus, for many lower-income households, the Marketplace plans are more generous than employer-sponsored insurance.

However, if employers offer HRA plans to their employees, this generally precludes workers from getting premium subsidies for Marketplace coverage or qualifying for cost-sharing reductions because the HRA contribution is considered an employer offer. Given that the Marketplace subsidies for lower- and middle-income families were extended through 2025 under the Inflation Reduction Act, enrollment in an HRA may be worse for lower-income workers than getting no employer funding whatsoever and therefore qualifying for the Marketplace’s enhanced tax credits and cost-sharing reductions.

Related to the aforementioned flexibility, however, a potential downside of HRA plans is that the proliferation of choices in the Marketplace and the individual insurance market threatens to create choice overload, especially for consumers with low-health literacy. A government report found that the average Marketplace enrollee has more than 100 plans to choose from, and this choice overload is only partially addressed by federal regulations on standardized plans and consumer shopping tools on HealthCare.gov.6 The relative value of fewer choices in employer-sponsored insurance vs more choices on the Marketplace hinges on the degree to which human resources teams in firms offering employer-sponsored insurance, which generally provide a small number of curated plan offerings, add value to consumer decision-making compared with individual insurance brokers, individual navigators, or the Marketplaces themselves.

Taking all these aspects into account, how should policymakers best harness the powers of the HRA tiger? Better data are needed on HRAs. Systematic information on what types of firms are offering HRAs, which employees are using them, and what kind of coverage the employees are obtaining is critical. Revising federal surveys such as the Medical Expenditure Panel Survey of Employers, as well as the recent decision by the Centers for Medicare & Medicaid Services to collect information about HRAs among Marketplace and other individual insurance enrollees are the most promising avenues to collect information.

These data can support rigorous evaluation and answer critical questions about the value of HRAs. If HRAs are enabling workers in small firms to pick plans that work well for them (in lieu of coverage that did not fit their needs or being uninsured), then HRAs may represent a substantial improvement in health care access. On the other hand, if HRAs are primarily replacing generous and well-curated employer-sponsored insurance plans with a potentially overwhelming number of
nonsubsidized, individual plans with high cost sharing, then this would be an experiment
worth ending.

Depending on the evidence that emerges, 2 potential policy improvements could include (1)
allowing workers who receive HRA contributions from employers to remain eligible for Marketplace
subsidies, offset by the amount of the HRA; and (2) revising the tax code to allow workers who use
HRAs to buy Marketplace insurance to deduct their share of the premiums from their taxable income
(currently this is only permitted when using HRAs for non-Marketplace coverage). These changes
might represent a best of both worlds approach, combining flexibility and affordability.

For now, the HRA liger appears unlikely to supplant the dominant creatures of the current
private insurance system, but it nonetheless bears watching.