

## **Wherefore Art Thou?**

### **Small business, healthcare coverage, and group association**

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#### **Abstract**

Small business/group research in health insurance is academically compelling given the dearth of literature, and insightful from both a theoretical and practical standpoint. The small group is a statutorily defined, government-regulated, and vital insurance market. We investigate why (and how) small firms manage to offer employee healthcare coverage despite the substantial costs and their employer mandate exemption. A corollary question is how they might band together and collaborate to further contain rising premium costs, gain leverage with insurers, and overcome mandatory protections and standards for small group plans. We find strategic differences between plans offered by small and large groups through which small groups might mitigate costs and trade-offs arising from employer propensities, plan design and benefits, financing, risk management, and associational options. Minimizing transaction costs of search and information, bargaining and decision-making, and monitoring and compliance, and market signaling within and between small firms to contain information asymmetries, are also key to achieving cost-efficiency in employer healthcare coverage.

**Keywords:** small business/group; employer-sponsored health insurance; Affordable Care Act (ACA); small group market; association health plan; actuarial risk

**JEL Classification:** G22, I11, I13, I18

#### **I. INTRODUCTION**

Employer-sponsored health insurance, alternatively called “group health insurance,” is the largest form of healthcare coverage in the United States, insuring 157 million people or over 58 per cent of the non-elderly population under age 65 besides their dependents (KFF, 2019). In a fully-insured health plan, the employer pays premiums to the insurer in exchange for the latter’s coverage of the costs of, and financial risks associated with, their employees’ healthcare over a defined period of time. The fully-insured group market includes both small group and large group health plans. It excludes employer-sponsored plans that are completely or partially self-funded (Morrisey, 2020).

The small group is a statutorily defined, government-regulated, and vital market in health insurance, with over 13 million covered lives (AHIP, 2019). In most states, a small group health plan is a group insurance product covering small business firms, not-for-profit organizations, and associations of any kind (e.g., local chamber of commerce or florists

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association) having one to 49 full-time equivalent employees (FTEs). In four states (California, Colorado, New York, and Vermont), a small group is capped at 100 FTEs. In any case, a small group with less than 50 FTEs is automatically exempt from the so-called “pay or play” mandate of the ACA (Affordable Care Act). Almost 97 percent of all U.S. firms have less than 50 FTEs and thus qualify for this employer mandate exemption (U.S. Census Bureau, 2016). The ACA’s employer mandate requires that any firm with 50 or more FTEs either provide “affordable” and “minimum value” healthcare to their workers and dependents, or else pay a hefty tax penalty toward a publicly-provided system that covers uninsured Americans (IRC, section 4980H, 2015).

The small group market remains under-explored and understudied. And of the five major health insurance markets in the U.S. (individual/non-group, small group, large group, Medicare Advantage, and Medicaid managed care), there has been little policy discussion about the fully-insured, small group market (Hall and McCue, 2018). This is particularly telling, considering that American business is overwhelmingly small group. Small groups with less than 10 workers make up 62 percent of all U.S. employers, while those with less than 20 workers represent over 89 percent of all U.S. employers (U.S. Census Bureau, 2016).

The scarce academic literature suggests that small group objectives and incentives behind healthcare coverage are employee attraction, retention, and productivity (Chamberlain and Tian, 2016), but often in a way that might also establish some comparative advantages to the organization and/or its owner. Cost — and its long-run risk implications — remains the prime disincentive to small groups (Long, Rae & Claxton, 2016; Mayer, 2020). Smaller risk pools and limited actuarial experience resulting in higher premiums, higher administrative costs per employee, and lack of dedicated staff to administer health plans make small groups much less likely to offer health insurance than larger employers (AHRQ, 2020). Yet, over half of small firms with less than 50 FTEs still offer health insurance (Miller, 2016; Hall & McCue, 2018).

Little else is known about small group health insurance beyond these incentives and challenges. In exploring organizational behavior, particularly information asymmetry, healthcare decision-making, and signaling between small businesses, the question for analytical investigation is why (and how) small firms still manage to offer healthcare coverage to their workers despite its substantial cost. A corollary question is how small firms might band together and collaborate to further contain cost and overcome mandatory standards and protections imposed by law on small group health plans. We seek to fill in the gaps in the insurance and risk management literature on small groups by illuminating the strategic choices, alternatives, and consequences of offering healthcare coverage either as a small business or through an association of small businesses. In doing so, we may further contribute to the literature on AHPs by distinguishing small groups from large group AHPs and clarifying their strategic advantages and limitations.

## II. METHODS

The small firm or group ( $\leq 49$  FTEs or  $\leq 100$  FTEs in the four previously named states) is our

unit of analysis, rather than their insured employees. Conversely, a large business or group has at least 50 or 101 FTEs, as the case may be. In exploring and analyzing organizational choices, decision-making, and communication, we compare small firms to large firms along several health insurance dimensions. The terms “business”, “firm”, and “group” are used interchangeably in this study. After all, these terms encompass any organization engaged in commercial, industrial, and/or professional activities in both private and public sectors, whether for-profit or not-for-profit entities.

We utilized two datasets to address our research questions. Our primary source was the SPSS-formatted, public-use dataset of the *Employer Health Benefits, Annual Survey* (EHB-AS) for five consecutive years (2015-2019) following full implementation of the ACA’s market reforms. This time frame also spans the period before and after the federal tax penalty for not carrying minimum health insurance, known as the individual mandate, was eliminated effective January 1, 2019 through the Tax Cuts and Jobs Act of 2017. The Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET) conducted during the five-year period 1,900 to 2,160 interviews annually with randomly selected non-federal public and private firms to generate single, point-in-time snapshots of employer-sponsored health benefits, plan costs, and selected health insurance issues. We disaggregated survey data, first by firm size so that our small firm sample conforms to the ACA, and then by particular insurance attributes. Small firm data was statistically tested for significance ( $p < .05$ ).

Our second source was the one-year (2019) public-use database of AHPs generated by Association Health Plans, Inc., supplemented by interviews with some of their officers. Their survey corresponds to the last year of the EHB-AS dataset and offers a snapshot of the demographic characteristics of AHPs in 37 states that allowed them to fully operate. We similarly disaggregated survey data by association demographics and plan attributes.

Pertinent data was tabulated for analysis in the seven succeeding sections of this study. Owing to journal space restrictions, some tabulations had to be compressed and/or combined into one.

### III. FINDINGS

#### **Statutory incentives and constraints**

The ACA applies essentially the same set of regulations to the small group market as it does the individual or non-group market from which the self-employed, uninsured, underinsured, and government-subsidized (but Medicaid-ineligible) low-income workers can buy healthcare coverage (Hall and McCue, 2018). Mandatory standards and protections for these plans include a minimum set of “essential health benefits”; the prohibition against using preexisting health conditions for enrollment eligibility and pricing; dependent children’s coverage until age 26; modified community rating (i.e., insurers cannot vary rates based on health status); a maximum pre-enrollment wait time of 90 days; guaranteed issue and renewal of insurance regardless of health status; and a limit on the percentage of premiums that can go towards insurer profit and overhead (known as the minimum “medical loss ratio”).

The ACA further established tax incentives for small firms to offer health insurance. Major drawbacks stem from, or in relation to, these statutory incentives. Healthcare tax credits equal to 50 percent of employer premiums are offered by the ACA to any sponsoring but small firm with less than 25 FTEs, which represents about 92.5 percent of all U.S. firms (U.S. Census Bureau, 2016). Tax credits are meant to encourage employer premium contributions and allow qualified small firms to better compete with large firms for skill and talent. However, the stipulated criteria is onerous and confusing to many small firms (Miller, 2016). By only offering to their FTEs plans under the ACA-created Small Business Health Options Program (SHOP), the mandatory average annual employee salary within a small group must be less than an annually indexed amount ( $\leq$ \$56,000 in 2025). In addition, the employer has to pay 50 percent or more of the premium for at least a single (employee-only) coverage plan. Tax credits are not applicable to the owner's premiums, exclude administrative costs beyond a certain yearly amount, and applies for a maximum of only two tax years. Hiring the 26th employee under this incentive scheme therefore has an immediate budgetary impact that disqualifies the employer from the tax credits. In terms of organizational behavior, the result is that these statutory credits are largely unused by small groups (Miller, 2016).

One hundred percent of employer-paid premium cost in any health plan (including health savings accounts and health reimbursement arrangements) is deductible from federal business taxes by an employer of any size. However, less than 20 percent of small business owners considers this as an incentive to offer health insurance. This is the case even among small firms in the four states with more (i.e., 50 to 100) workers who are subject to the employer mandate. The fast rising cost of healthcare coverage, including healthcare inflation, to the employer since the ACA's enactment could thus outweigh the tax benefit, although it may be an incentive to some employers (Miller, 2016).

Following the ACA's full implementation in 2014, small groups that have no more than 100 employees could obtain small group insurance from any of the following sources: 1) the federal SHOP exchange/marketplace; 2) by direct purchase from an insurance carrier/insurer; and 3) through an insurance broker or agent. Third party administrators may be hired by small groups to offer plan-related administrative services.

Before the ACA's passage, insurers routinely charged small firms higher premiums of 18 percent or more because it also costs more to insure smaller worker pools, whose collective risk tends to be higher than a much larger group, whose risks are more spread out and actuarial experience more reliable (NCSL, 2018). The ACA put together small groups in the SHOP (or a comparable state exchange) as if they were one greater risk pool, granting groups that buy health insurance through SHOP or state exchanges the same kind of group bargaining and purchasing power that larger businesses enjoyed exclusively, pre-ACA (NCSL, 2018).

However, our survey data indicates that since the ACA became effective, the SHOP exchange has been the least used by small groups with less than 50 FTEs. Only about 13 percent of them purchased from this exchange (KFF/HRET, 2015; KFF/HRET, 2016). Although rates were group-discounted, almost two-thirds of surveyed small business owners found the SHOP exchange plans either expensive or restrictive (e.g., at least 70 percent of small firm workers had to enroll in any of them). Two-thirds eventually found better plan rates elsewhere, by direct purchase, or through their brokers and agents (KFF/HRET, 2015; KFF/HRET, 2016). With risk

pools declining in size and mix in the next four years, the federally facilitated SHOP exchange, covering 33 states, closed by the end of 2017. Small firms were then directed to insurance carriers or to the remaining SHOP-registered agents and brokers (Jost, 2017). In most states, small firms also communicate and signal through these representations to pool together (i.e., through purchasing pools or CO-OPs) and buy SHOP plans and AHPs.

Direct purchases from insurance carriers entail transaction costs on the part of the employer. Health insurance markets in the U.S. are “characterized by imperfect information, complex products, and substantial search frictions” (Karaca-Mandic *et al.*, 2018). Particularly time-consuming and administratively demanding are search and information costs (e.g., comprehending and comparison-shopping for plans), as well as bargaining and decision costs, including matching plan offerings with employee demographics and preferences and making plan-related choices (Morrissey, 2020). As many as 87 percent of our surveyed small firms thus rely on commission-based brokers and agents to purchase, upgrade, or replace their health plans (Karaca-Mandic *et al.*, 2018).

### **Small group propensities**

Firm size based on FTE count is a strong predictor of small group healthcare coverage ( $r = 0.84$ ), as depicted in Table 1. The larger the workforce, the higher is the probability that a small business (<50 FTEs) will offer at least employee-only healthcare coverage. This positive correlation can be gleaned in both pre-ACA and ACA years. The average ( $x$ ) percentage of sponsoring small firms over a five-year period (2015-2019) ranged from approximately 45 percent (i.e., with 3-9 employees) to 63 percent (10-24 employees) to 78 percent (25-49 employees). A similar finding pertains to small firms that are subject to the employer mandate (50-100 workers) but nonetheless benefit from certain statutory incentives (e.g., SHOP plans). Around 92 percent of businesses with at least 50 workers sponsored health insurance. Small businesses that do not offer it tend to be much smaller in terms of workforce size (<8 FTEs), rely more heavily on a part-time workforce, and/or tend to employ lower-income workers.

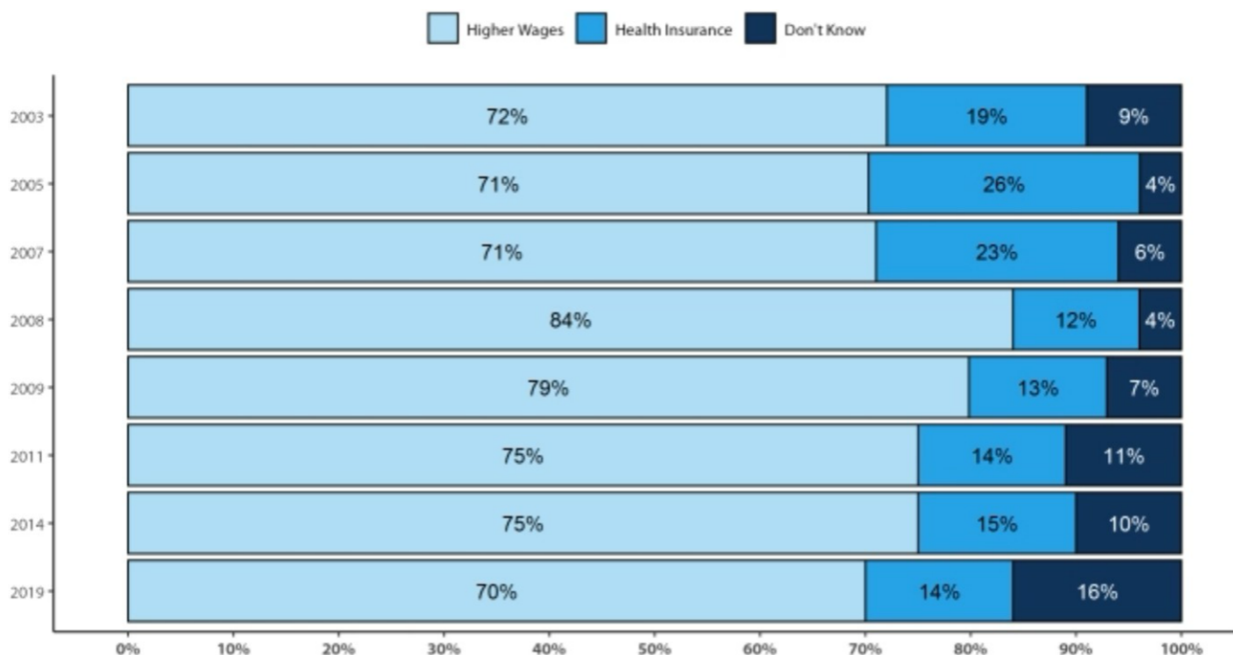
Because almost 9 out of 10 small business owners use brokers and agents to choose their employer-sponsored health plan design and benefits (KFF/HRET, 2015-2019), one could fairly assume the competitiveness of premiums and employee cost-sharing in small group plans (eHealth, 2018). On the other hand, from an organizational behavior perspective, the employer incentive differential stemming from premium affordability to, and desired benefits package of, the owner is suggested by the KFF-HRET data on the compensating wage differential in Figure 1. This refers to the minimum additional amount of income that workers will have to be offered in order to motivate them to accept or perform their jobs either in the absence, termination, or reduction of insurance coverage (Rosen, 1986; Kaufman, 2005). Asked in the KFF/HRET surveys whether they believe their insured employees would rather receive an additional \$2 per hour wage increase instead of healthcare coverage, as many as three-fourths of small business owners consistently responded in the affirmative over the years. Yet, these same owners are also very unlikely to opt for a wage differential which could be more expensive, as salary increases and inflation costs over time compound on the \$2 additional wage.

**Table 1. Employer-sponsored health insurance by small firm size (average % of sponsoring firms)**

Firm size (# employees)	2000 (x = 68)	2002 (x = 65)	2004 (x = 62)	2006 (x = 60)	2008 (x = 62)	2010 (x = 68)	2015 (x = 56)	2016 (x = 55)	2017 (x = 53)	2018 (x = 56)	2019 (x = 56)
<10	57	58	52	49	50	59*	47	46	40	47	47
10-24	80	70*	74	73	78	76	63	61	66	64	63
25-49	91	87	87	87	90*	92	82	80	78	71*	77
50-199	97	95	92	92	94	95	92	91	92	91	93

\*Estimate is statistically different from the immediately preceding year, whether or not the preceding year is indicated in Table 1 ( $p < .05$ ). Because KFF/HRET surveys collect information from a large sample of all U.S. firms, even seemingly large differences among them may not necessarily be statistically significant from year to year.

**Figure 1. Small firm assessment of compensating wage differential\***



\*No statistically significant differences in percentage distributions ( $p < .05$ ) were observed from year to year in the period covered.

Source: KFF (2019). *Employer health benefits: 2019 annual survey*. San Francisco, CA: KFF. Wage differential question asked of sampled small businesses/owners was whether they believe their employees would rather receive an additional \$2.00 per hour in salaries/wages in lieu of employer-sponsored health insurance. This question was asked in the KFF/HRET surveys only in years indicated in Figure 1.

Take-up rates among small and large firms are contrasted in Table 2. Take-up refers to the proportion of eligible employees who actually enroll in employer-sponsored health insurance. This excludes workers who opted out of obtaining coverage from their employer because federally subsidized insurance from the individual market and (broader) access to Medicaid under the ACA offered better alternatives to small group insurance.

Even among small firms, the five-year take-up rate is high enough, averaging over 75 percent. It is only slightly, albeit statistically, different ( $r = 0.73$ ;  $p = 0.44$ ) from the average take-up rate in large firms ( $x = 78.2$  percent) during the same period. On the one hand, high take-up rates among small business workers anchors the propensity of small business owners to offer health insurance in place of a compensating wage differential. On the other hand, they appear to validate the value-added contribution of healthcare coverage to human resource goals, including employee attraction and recruitment, retention, and productivity (Chamberlain and Tian, 2016; AHIP, 2018).

**Table 2. Eligibility and take-up rates (%) in small group health plans**

Plan eligibility and take-up	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
<b>Employees eligible for employer health insurance</b>	83*	79*	83	80	83*	80*	83*	79*	84*	80*
<b>Eligible employees who participate in employer health insurance</b>	76*	79*	77*	79*	76*	78*	74*	77*	73*	78*

\*Eligibility or take-up rate is statistically different between small and large groups in the given year ( $p < .05$ ).

### Plan design and attributes

Which plan design/type and benefits small groups choose to offer and how much the employer and insured worker (enrollee) contribute typically result from back-and-forth communication with and negotiation through their brokers and agents (KFF/HRET, 2015-2019). Rarely are worker preferences surveyed actually by employers. But plan information is communicated to workers during recruitment, the open-enrollment period, and for qualifying life events.

Certain plan characteristics and attributes statistically differ between small and large businesses, offering decision-making insights into how small businesses finance and retain healthcare coverage, despite their substantial and rising costs.

Approximately 8 in 10 small groups in Table 3 offer only one type of plan, often a PPO

which enrolled around 46 percent of all small group workers between 2015 and 2019. In contrast, statistically higher numbers of large firms, averaging 75 percent from 2015 to 2019, offered a PPO. In a PPO, enrollees may seek care outside the provider network, but generally pay higher premiums and cost-sharing for network providers (e.g., copays, deductibles, co-insurance, maximum out-of-pocket cost). Large firms are equally likely to offer one (45 percent) or two (42 percent) plan types; they are more than four times likelier to offer three or more plan types than small firms.

**Table 3. Small group healthcare coverage by plan design and attributes (%)**

Plan structure	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
<i>Plan types (#) offered:</i>										
—One	84*	52*	84*	47*	83*	45*	81*	42*	76*	39*
—Two	12*	39*	14*	37*	15*	42*	16*	45*	20*	47*
—Three or more	3*	9*	2*	16*	2*	13*	3*	13*	4*	14*
<i>Type of plan:</i>										
—Conventional indemnity	1	2	2	2	2	1	<1*	1*	3	1
—HMO	17	23	22	27	17*	31*	32	25	26	26
—PPO	49*	77*	34*	73*	49*	73*	49*	75*	48*	78*
—POS	27*	14*	33*	17*	28*	10*	14	11	24*	14*
—HDHP (may have HSA, HRA, other SOs)	25*	41*	27*	51*	23*	53*	27*	58*	27*	57*
<i>Plan coverage:</i>										
—Single coverage only	2	0	11	0	5	0	5	0	6	0
—Spouse	98	100	89	99	94	100	97	99	94	99
—Children and other dependents	96	100	88	100	92	100	95	100	94	100

\*Percentage distribution is statistically different between small and large groups for the given year ( $p < .05$ ).

HDHPs (high deductible health plans) ranked second among the plan offerings of a large firm (52 percent). A plan is considered an HDHP if the single (individual) and family deductibles met or exceeded the IRS-prescribed annual deductible (\$1,650 for single coverage and \$3,300 for family coverage in 2025). Traditionally paired with health savings accounts (HSAs), HDHPs have much lower premiums than a fully-insured plan (e.g., PPO, HMO, POS, EPO). The major disadvantage of an HDHP is the generally staggering out-of-pocket costs to

the enrollee and their family because the annual deductible is also way higher (Morrisey, 2020). This financial risk to the insured, along with lower average wages in small firms, suggest why only one in four small firms offered an HDHP in Table 3. Cost-sharing in small businesses, particularly for in-network providers and services, tends to be lower than in large group HDHPs. The same strategic risk-aversion is observed among small firms that adopted a self-insured/funded plan which transfers risk exposure directly to the employer (Park, 2000; Morrisey, 2020). An average of only 15 percent of small groups in Table 3 chose to self-insure compared to over 62 percent of large groups where it is the predominant plan design (KFF/HRET, 2015-2019).

In terms of actuarial value, nearly or slightly over one-half of small firms tend to offer a silver-tier plan or its equivalent (KFF/HRET, 2015-2019). This carries a 70 percent actuarial value, which is the portion of medical expenses that a health plan covers on average compared to the enrollee's cost-sharing responsibility (in this case, 30 percent). A silver plan has lower monthly premiums, but enrollee cost-sharing is higher than the gold and platinum plans which respectively carry 80 and 90 percent actuarial value. Most large firms prefer to offer a gold-tier plan or its equivalent.

The number of covered lives may provide yet another indication of cost-containment among small firms. Despite significant variance from year to year in Table 3 (minimum = 2 percent; maximum = 11 percent), some small firms offer employee coverage only, while none of the large firms do so. Spouses, children, and other dependents (e.g., same-sex partner) can be extended coverage in nine out of 10 small group health plans, and practically 100 percent of large group insurance, although differences in some years were statistically insignificant.

### **Plan financing**

How much and in what ways will a small business finance employee healthcare coverage are usually owner and/or management decisions which underpin plan design. Key considerations include the *pure premium* and the *loading fee* or expense ratio covering insurer profit/mark-up for objective risk, marketing costs, benefits coordination, claims processing and adjudication, and other administrative overheads (Green, 2021). The reviewed literature is helpful in pointing out that such decisions are not exclusively budget-driven but linked to employee recruitment, retention, and productivity, especially considering that employee turnover in small groups is generally higher (Mendoza, 2024).

Table 4 shows that annual premium rates for employee-only coverage in small groups averaged \$6,622 for five years, which are not statistically much different from large groups ( $x = \$6,722$ ). Average premium growth rate is around 4 percent annually for small and large groups alike. But the financial burden on small firms is much heavier, with single premium rates constantly rising (or skyrocketing). An eHealth survey, for example, reported that 78 percent of small business owners were either somewhat or very concerned about being able to continue paying for employee healthcare due to increasing rates. About 62 percent indicated that a 15 percent premium increase would be unaffordable, forcing them to drop or reduce coverage or shop for a new plan (eHealth, 2018). These lend empirical support to the employer's cost-calculus between insurance affordability and strategic human resource objectives.

**Table 4. Average annual premiums, small group health insurance, all plan types**

Premium attribute	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
<i>Average total premium (\$)</i>										
—Single coverage	6,163	6,289	6,429	6,438	6,486	6,776	6,814	6,930	7,218	7,175
—Family coverage	16,625*	17,938*	17,546*	18,395*	17,615*	19,235*	18,739*	19,972*	20,236	20,717
<i>Average total premium by firm ownership (\$)</i>										
—Private for-profit	5,841**	5,934**	6,164**	6,021**	6,204**	6,339**	6,659*	6,665*	7,010*	6,714*
—Private not-for-profit	7,039**	6,829**	7,124**	6,863**	7,194**	7,061**	7,213*	7,281*	7,406*	7,669*
—Public	6,962**	6,860**	7,543**	7,060**	7,350**	7,549**	6,964*	7,387*	8,587*	7,923*
<i>Average employee premium (\$ contribution (% total premium))</i>										
—Single coverage	899(15)	1,146(18)	1,021(16)	1,177(18)	1,030(16)	1,290(19)	1,133(17)	1,207(17)	1,035(14)	1,330(19)
—Family coverage	5,904(36)*	4,549(25)*	6,597(38)*	4,719(26)*	6,814(39)*	5,264(27)*	6,782(36)*	5,046(25)*	7,805(39)	5,271(25)
<i>Average employer premium (\$ contribution (% total premium))</i>										
—Single coverage	5,264(85)	5,142(82)	5,408(84)	5,261(82)	5,456(84)	5,486(81)	5,681(83)	5,723(83)	6,183(86)	5,845(81)
—Family coverage	10,720(64)*	13,390(75)*	10,949(62)*	13,676(74)*	10,801(61)*	13,971(73)*	11,957(64)*	14,926(75)*	12,431(61)	15,446(75)

\*Percentage distributions are statistically different (horizontally) between small and large groups in terms of corresponding premium-related attribute ( $p < .05$ ).

\*\*Percentage distributions are statistically different (vertically) only by firm ownership category within small or large groups, but not (horizontally) between any other premium-related attributes ( $p < .05$ ).

It is in the family coverage premiums where small and large businesses statistically differ in Table 4. The five-year average is lower among small firms (\$18,152) in contrast to large ones (\$19,251), although both increased yearly at an average of 5 percent. Since small group health insurance tend to have higher loading fees, particularly administrative and marketing costs (Long, Rae & Claxton, 2016), lower family premiums in small firms implies that healthcare benefits are also less generous on average. Offering affordable family coverage, even for less generous benefits, could nonetheless help attract and retain needed talent in small businesses.

Table 4 also shows that small and large employer contributions to single plan premiums do not statistically vary, both averaging slightly over 80 percent from 2015 to 2019. Most enrollees in small firms contribute approximately 16 percent of total premium cost. However, small and large firms vary with respect to family plan contributions. Small employer contributions were consistently around 60 percent of premium cost ( $x = 62$  percent). Large

employer contributions were consistently at a much higher rate, in the mid-70s ( $x = 74$  percent) during those five years. Thus, small group workers pay 12 percent more in family premiums ( $x = 38$  percent) than their counterparts in large groups. The difference likely accounts for greater budgetary and other financial constraints faced by small businesses in covering employee spouses and dependents.

Employee-paid premiums statistically vary once stratified by group ownership in Table 4. Higher premiums are consistently charged by public ( $x = \$7,481$ ) and private not-for-profit ( $\$7,195$ ) firms compared to private for-profit firms ( $\$6,376$ ) in either small or large group markets. Pricing differences suggest more generous benefits offered by public and private not-for-profit health plans.

### **Risk management**

Health insurers resort to favorable selection, HMO-style disincentives, utilization review, and other enrollee-focused approaches to reduce risks of adverse selection and healthcare over-utilization or moral hazard by the enrollee (Morrisey, Kilgore *et al.*, 2013; Morrisey, 2020). Small firms have less options available in containing the financial burden or implications of enrollee behaviors once these small firms elect to offer coverage (Morrisey, 2020), but our findings suggest some approaches might be strategically advantageous.

For one, Table 5 indicates that small groups are more predisposed to offer healthcare coverage with higher deductibles than large groups. This means enrollees pay 100 percent of covered treatments and services until a stipulated dollar amount is reached at which time the group health plan starts to pay while enrollee is charged coinsurance. That dollar amount is generally higher in small groups. Even if there are fewer small group HDHPs, the number of their workers in single coverage HDHPs with deductibles of \$2,000 or more is typically higher than large groups. Average single coverage enrollment in these plans for small and large groups, respectively, are also statistically significant from 2015-2019:

\$1,000 deductible: 64 percent; 46 percent  
 \$2,000 deductible: 42 percent; 17 percent  
 \$3,000 deductible: 23 percent; 7 percent

Generally, the higher a plan's deductible, the lower the premium cost, as more risk is ostensibly shifted to the enrollee who exposes more “skin in the game” (LaMontagne, 2014; (Agarwal et al., 2017). In this sense, offering health insurance becomes an employer or business owner balancing act between deductibles and premiums. Because small groups pay the majority of premium costs in both single and family plans (see Table 4), the employer (and employee) generates premium-savings from higher deductibles, which in Table 5 are sometimes at levels usually unseen in large group plans for the years covered in this study (e.g., \$3,000). Combined with the small group’s propensity to offer only one plan or one plan design/type (Table 3), health plans with higher deductibles also lead to administrative and other transaction cost-savings to small groups. The cost of claims processing and adjudication alone decline with reduced healthcare access (Green, 2021). Yet, there is no gainsaying that the effectiveness of higher

deductibles can hinge on whether workers in a small group are predominantly low-income, younger or older, healthy or living with a chronic condition, etc. (Agarwal et al., 2017), considering that the primary goals of small group insurance relate to job satisfaction, especially after it has produced an incentive differential to the owner or employer.

**Table 5. Cost/risk management approaches among small firms offering health insurance (%)**

Cost/risk reduction	2015		2016		2017		2018		2019	
	Small	Large	Small	Large	Small	Large	Small	Large	Small	Large
<b><i>Insured employees in (single) plans w/ high annual deductible:</i></b>										
≥\$1,000	63*	36*	65*	41*	58*	48*	68*	54*	68*	50*
≥\$2,000	39*	12*	45*	16*	37*	15*	42*	20*	45*	22*
≥\$3,000	—	—	—	—	22*	6*	22*	7*	24*	9*
<b><i>Firms adopting narrow(er) network plan/s**</i></b>										
	8	9	7	6	8*	11*	6*	10*	5*	11*
<b><i>Firms eliminating hospitals/healthcare systems from their networks in past year**</i></b>										
	10	6	6	5	6	4	2*	5*	1	3
<b><i>Firms that searched for new plan/carrier in past year:</i></b>										
— Shopped for new plan/carrier	47*	38*	52*	35*	59*	37*	62*	50*	53	49
— Shopped + changed plan/carrier	24	24	21	27	29	26	26*	20*	18	22
<b><i>Firms offering incentives to employees enrolling in spousal plan</i></b>										
	9	11	10	12	15	13	13	12	—	—
<b><i>Firms w/ incentives to employees for not enrolling in employer plan (if w/ out spouse/spousal plan enrollment)</i></b>										
	7	5	9*	15*	18	17	16	15	—	—
<b><i>Non-offering firms providing funds/reimbursements for employees to buy insurance on their own***</i></b>										
	17	—	11	—	16	—	9	—	11	—
<b><i>Non-offering firms that terminated health insurance***</i></b>										
	25	—	19	—	13	—	20	—	13	—

\*Percentage distribution is statistically different between small and large groups ( $p < .05$ ).

\*\*Around 5% of small groups on average considered either a narrow(er) plan network (< providers) or eliminating hospitals and healthcare systems from their networks in the past year to reduce cost.

\*\*\*Refers to small groups that either do not offer group health insurance, or have terminated it.

—Not surveyed/reported by KFF/HRET during the corresponding year.

Table 5 suggests that small firms tend to communicate more frequently with brokers and agents during the year to *shop* for new health insurance and/or carrier offering lower premiums and deductibles and/or broader provider networks. Statistically significant for all five years, except 2019, 50 percent or more of small firms shopped for replacement plans and/or carriers to contain cost, as opposed to less than 40 percent of large groups. Other risk mitigation strategies

sometimes used by small firms, but generally *not* any statistically different from large firms, include offering narrow(er) provider networks, eliminating certain hospitals and healthcare systems from their current network, and terminating their current health plan and/or carrier. In this sense, brokers and agents help offer lower premiums, especially in more competitive broker/agent markets. Premiums are also less dispersed in these markets (Karaca-Mandic *et al.*, 2018).

Table 6 indicates that many small and large firms alike choose to set up risk management programs or options within their health plans to help enrollees identify health issues and manage chronic conditions. Plan offerings include health risk assessments, biometric screenings, and health promotion programs (Mendoza, 2025). Like large firms, too, small groups do not typically offer employee incentives either to enroll in spousal plans or non-employer plans in lieu of participating in their employer-sponsored health insurance.

**Table 6. Risk management programs/options offered in small and large group health plans (% all plan sponsors)**

Year	Programs to help stop smoking	Programs to help lose weight	Other lifestyle/behavioral coaching	Disease mgmt. programs	At least 1 other wellness program*	Penalty for tobacco use or vaping
2015	42	40	40	33	50	-
2016	38	35	38	-	47	-
2017	41	35	47	41	59	16
2018	45	43	40	-	54	17**
2019	37	32	40	29	51	-

\*Most common examples include: classes in nutrition and healthy living, gym membership discounts/credits, on-site exercise facilities, and wellness benefits offered to spouses/dependents.

\*\*Only large firms of  $\geq 200$  workers were surveyed.

– Not surveyed/reported by KFF/HRET during the corresponding year.

### The lure of group association

When healthcare coverage costs increase and become challenging to small businesses or comparison-shopping yields less costly options, Table 5 suggests that small businesses rarely consider, or at least implement, alternatives to fully-funded plans (13 percent), including self-funding, unlike their large business counterparts. Brokers and agents are also unlikely to suggest self- or partial-funding, given their fee-based incentives. Group insurance still appears to be

more cost-efficient and attractive even to small business employees (Freedman, 2020). Instead, association health plans (AHPs) might offer a more viable alternative (Mendoza, 2024). For that reason, we explore in this section the strategic advantages and limitations of forming AHPs.

The ACA and other federal regulations allow small groups to band together and form an “association” to purchase fully-funded health insurance through an insurer-issued AHP, unless they opt to associate to self-fund their AHP. Primarily intended to encourage small groups to sponsor healthcare coverage that might otherwise be prohibitively expensive if separately purchased from the small group market, AHPs can better pool similar risk groups (e.g., various small realty firms or bakeshops, rather than one single realty firm or bakeshop). AHPs thus gain better leverage and can take advantage of greater cost-savings typically available only to large group plans. AHPs also tend to “have lower administrative costs, perhaps because of [their] ongoing relationship and communication with members” (Morrisey, 2020: 366).

Certain ACA healthcare reforms apply only to small group (and non-group) insurance plans to protect them from their inherent disadvantages in pricing and coverage. After all, insurers have little incentive to offer — and small firms and individual purchasers have little leverage to negotiate — comprehensive benefits, in light of the higher actuarial risks of insuring a smaller pool of workers (Chaikind *et al.*, 2010). As noted earlier, these mandatory protections and standards include the 10 essential health benefits that plans must offer; tiered actuarial values that specify policy-holder and insurer cost-sharing for covered benefits; modified community rating method that allows premiums to vary only by age, tobacco use, geographic location, and family size; single risk-pooling so that underwriting is based solely on the pooled health risks of policy-holders; and “risk adjustment” by which health plans that disproportionately enroll higher-risk people receive payments from plans that enroll younger and healthier individuals. These reforms are costly to many small group and non-group insurers (Mendoza, 2017). The ACA drafters did not impose them on fully-insured and self-insured large group plans because “they felt that these plans’ covered benefits... were as good if not better” than what the ACA prescribed for the small group and non-group health plans (Condeluci, 2018: 6). There was likewise the presumption that large groups are in a better position to negotiate and bargain with insurers, and therefore, do not need as many protections (Condeluci, 2018).

Interviews with AHP Inc., an interest group representing various AHPs, underscore two key aspects of group associations offering AHPs in lieu of traditional small group plans. The first is legitimacy of organizational scope. Commonality of interest (small group members belong to the same trade, industry, line of business, or profession) is required by U.S. Department of Health and Human Services (HHS) implementing regulations. Another issue that AHPs, especially newly set up ones, often need to contend with at the state level is a “seasoning requirement.” The association (not the small group) sponsoring the AHP must be of minimum age (often three years old) to discourage “fly-by-night” associations and fraudulent carriers, brokers, and agents (Coleman, 2024).

Efficient communication, especially in terms of signaling, is essential to small group association. These groups do not need to know one another prior to founding an AHP. Brokers and agents with AHP experience are hired do the needed groundwork and communications. Some small groups, usually with existing multiple business relationships, prefer to do it on their own. In this *de novo* scenario, those sharing an acceptable commonality of interest communicate

and meet up to perform several tasks: 1) Establish a formal sponsoring association with a governing body (e.g. directors or trustees) and by-laws; 2) Provide a defined structure for leadership roles (e.g. president, treasurer, etc.); and 3) conduct and report on regular meetings. Whichever route the association takes, there must be compliance with federal and state regulations, for which they may approach outside counsel with AHP expertise (Coleman, 2024).

However, AHPs are not without controversy. A 2011 HHS regulation practically disallowed small groups (with an aggregate total of over 49 or over 100 FTEs, depending on the state) from sponsoring a fully insured large group AHP after informing their insurers of their workforce size (HHS, 2011). This came amid fears that many small groups were fleeing the small group market for the AHP market, and were seeking equal treatment as a large group to contain skyrocketing premiums and operational costs without having to offer “just as good, if not better” standards and protections mandated by the ACA. AHPs that are treated as a large group plan tend to generate cost-savings to employer and employee alike better than a small group AHP by “negotiating [more] leverage based on economies of scale” and offering an even “bigger ‘risk pool’” (Condeluci, 2018, p. 9). The 2011 HHS regulation led to a drastic decline in fully-insured AHPs, after many of small firms chose to discontinue their AHPs amid the risk of non-compliance (Condeluci, 2018).

The first Trump administration sought to reverse the decline and directed the U.S. Department of Labor (DOL) — tasked with administering employee benefits law — to expand AHP availability (Executive Order 13813, 2017). The DOL did so by considerably loosening the definition (or interpretation) of a qualified “*bona fide group or association of employers*” under the 2011 HHS regulation. By 2018, the DOL had released a highly contentious “AHP rule” (known as Pathway 2), allowing small group associations to pass the commonality of interest test if: 1) member-groups are in the same trade, industry, line of business, or profession, regardless of geographic location; *or* 2) member-groups have their principal place of business in one state or metropolitan area (spanning a tri-state area), whether or not it spans more than one state (DOL, 2018). Removing the strict geographic limitation through the first criterion was “critical for national trade associations, franchisees, and companies with “cooperative” members... [and which have for decades] wanted to offer some type of health coverage to their [small] group members through a fully-insured or self-insured AHP *on a nationwide, or a regional basis*” (Condeluci, 2018: 9). The second criterion allows “unrelated” employers from different trades, industries, businesses, and professions (e.g., chambers of commerce), meeting the needed FTE aggregate counts, to sponsor an AHP, but only if they are principally located in the same state or metropolitan area. A major objection to Pathway 2 stemmed from the fear that associations based on different geographies and/or unrelated small businesses would expand AHP market share and draw people out of ACA risk pools, costing small group insurers more and raising small group premiums even more.

The DOL’s Pathway 2 went one step further by permitting self-employed individuals without employees (referred to as “working owners”) to act both as an employer sponsoring a group health plan and an employee participating in an AHP (DOL, 2018). These working owners could then participate in an AHP established by other “related” small groups (e.g., solo realtors who belong to a realty association) in the same industry/profession, even if they are located in different geographic areas. This provoked further opposition.

Several consumer advocacy groups, insurers, and state governments challenged small group formation of large group AHPs through federal litigation because of their exemption from ACA mandatory standards and protections for small group health plans. Consider the opposition of the American Medical Association and seven other physician organizations. They asserted that Pathway 2 serves to lure small groups into AHPs until a medical emergency strikes. It is then that they discover essential care is not covered, which is particularly devastating to economically vulnerable and unhealthy populations and their dependents (Golder, 2019). Others claim that Pathway 2 insurers can easily game the system through higher cost-sharing, narrower provider networks, and reduced coverages for large group AHP enrollees (Condeluci, 2018), thereby turning “associations as a vehicle for bootstrapping them into the large-group market” (Golder, 2019: 25).

### **AHP demographics**

Pathway 2 led to the rapid growth of AHPs starting in 2018. It allowed 3.2 million small groups to set up the equivalent of large group AHPs for their almost 50 million employees, and 27 million independent contractors to join an AHP for the first time (Cassidy, 2024). The 2019 AHP demographic survey provide context to the impugned DOL rule.

As much as 71 percent of 28 new AHPs since 2018 were set up by regional associations of small groups. Another six AHPs were in the process of forming by 2019. The vast majority of these 34 associations shown in Table 7 were chambers of commerce, some of which were multiple chambers sponsoring a single health plan (e.g., all 29 chambers in Vermont). Most benefitted from Pathway 2’s second criterion that allows small groups in different industries and professions (i.e., “unrelated” employers) but located in the same geography to form AHPs. Non-chamber regional associations included business groups (e.g., Small Business Association of Michigan), regional trade groups (Wisconsin Manufactures & Commerce), and philanthropic organizations (Business Fund for Texas Children Battling Cancer). On the other hand, multi-state professional AHPs, which limit membership to small groups within the same line of work/trade, took longer to reach the association market because they required more preparation and state filings. AHPs formed under the 2011 HHS regulation (i.e., prior to Pathway 2) are comparably much fewer in number (AHP.com & Coleman, 2023a).

Over 86 percent of the new AHPs in Table 7 were fully insured, rather than self-funded, as a large group plan. Preference for full insurance owed largely to AHP reliance on an insurer with greater capital resources to withstand catastrophic medical expenses (Morrisey, 2020). UnitedHealthcare and Blue Cross/Blue Shield were the most frequently chosen carriers. Fully-insured AHPs typically adopted strategies to mitigate adverse selection and promote financial stability, including a set minimum number of covered FTEs within the range allowed by the state in which the AHP resides, minimum period for association membership of a small group before accessing an AHP, and a wait time prior to small group withdrawal from the association (AHP.com & Coleman, 2023b).

**Table 7. Demographics of small firm associations/AHPs formed under Pathway 2 (n = 34)**

Association demographics	<i>f</i> (2018-19)
<b><i>Associations formed</i></b>	
–Active	28
–Inactive (i.e., under formation)	6
<b><i>Commonality of interest</i></b>	
–Regional* (same geography*; may be different lines of work/trade)	20
–Professional (only same line of work/trade; may be different geography)	8
<b><i>Minimum group size for association membership</i></b>	
–One (“working owner”)	12
–Two to 50 FTEs	15
–51 to 100 FTEs	1
<b><i>AHP funding</i></b>	
–Fully funded/insured	24
–Self-funded/insured	4
–Partially-funded/insured	0
–Inactive but leaning toward fully-funded/insured	6
<b><i>Plan types/options available (average #)</i></b>	
–Fully-funded/insured	11
–Self-funded/insured	11
–Partially funded/insured	0
<b><i>Benefits covered (essential care)</i></b>	
–Comprehensive**	28
–Limited/narrow	0
<b><i>Medical savings account options (e.g., HSA, HRA)</i></b>	
–Offered (at least one)	14
–None offered	14

\*Approximately 4 of 5 regional associations formed under Pathway 2 were sponsored by (single or multi-) chambers of commerce. Geographic location refers to municipality, city, county, regional, or state..

\*\*Minimum coverage includes doctor and specialist visits, hospitalization, emergency care, prescription drugs, maternity care, preventive care, and mental health care. Lack of coverage generally observed for pediatric dental care and pediatric vision care, but these benefits are not mandated by law in large group plans and may be offered through stand-alone dental and vision plans.

Although plan design and benefits were fairly similar to a traditional small group plan, cost-savings to large group-styled AHPs came primarily from premium rates that were at least 30 percent lower than those for ACA-regulated non-group and small group plans (CBO, 2019). In terms of scope of benefits, most of the new AHPs offered comprehensive coverage that resembled mandatory essential health benefits for non-group and small group plans. These included primary care physician and specialist visits, hospitalization, emergency care, prescription drug coverage, maternity coverage, preventive care, and mental health care. Where large group AHPs largely differed from ACA standards appears to be in (their lack of) pediatric dental care and pediatric vision care coverage, which might be offered through stand-alone dental and vision plans.

Half of the new AHPs additionally provided pretax savings account options, especially a health savings account, which the enrollee could use for out-of-pocket costs, including copays, deductibles, and coinsurance (AHP.com & Coleman, 2023a).

Half of these AHPs were also restricted in membership to small groups with two to 50 FTEs. Less than half (43 percent) were open to the self-employed (AHP.com & Coleman, 2023a). A total of four million workers were estimated to have enrolled in AHPs as of 2018 as a result of Pathway 2 (DOL, 2018).

However, the Biden presidential administration rescinded Pathway 2 in 2024 after federal litigation ensued, effectively returning AHPs to pre-2018 (HHS) regulatory guidance. There is talk of reviving it in some shape or form under the second Trump administration (2025-present). Nonetheless, several large group AHPs have either adopted small group standards and protections under the ACA or have individually insured their member-businesses as a small group while gaining for them AHP-like lower premiums and other cost-savings.

#### **4. DISCUSSION AND CONCLUSION**

Small business research into the health insurance market is academically compelling in light of the dearth of literature which essentially focuses on incentives and challenges to employer sponsorship of employee healthcare coverage. It is also insightful from a theoretical and practical business standpoint. We sought in this study to discover why (and how) small firms or groups as well as associations of these firms or groups manage to offer healthcare coverage in pursuit of human resource objectives and despite statutory exemptions and disincentives. We did so by inquiring into how small groups might overcome the substantial cost burden of plan sponsorship.

Our cross-sectional analysis of the EHB-AS dataset reveals that small business decision-making is more nuanced than the primordial objective of employee job satisfaction relative to recruitment, retention, and development of needed skill and talent. Doubtless, statutory incentives to small group healthcare coverage are in place. But they can be offset by restrictive or burdensome qualification requirements, leading brokers and agents to assume an important role in small group plan choices and alternatives. Because almost nine out of every 10 small firms employ them, premium rates can be quite competitive. Yet, no matter how competitive these rates may be, they also have to be affordable relative to firm size and income and employee demographics. After all, the majority of premium costs for both single and family plans are

employer-paid, besides the added operational costs that these small employers have to bear.

In this regard, we posit the view that an incentive differential equally plays an important role in steering small firms toward human resource objectives. To the extent that premium rates are deemed affordable by a small business, and/or group coverage makes the business owner better off than getting it elsewhere or remaining uninsured, it is likely that the small firm will sponsor health insurance. That is to say that cost-efficiency to a small firm and its owner (the employer differential) go hand in hand with the expected gains of employee job satisfaction in motivating small firm sponsorship notwithstanding the limited advantages of statutory incentives and the substantial costs of premiums and plan administration. Otherwise, the owner's cost-calculus might favor a compensating wage differential. Three-fourths of small business owners, in fact, believe that their workers would rather receive a higher wage than healthcare coverage.

With our findings, we distinguished organizational problem-solving and decision-making toward cost-efficiency within and between small firms. Doubtless, employees who enroll within their organization for small group health insurance have considerably more consumer protections, and their insurers have additional standards to meet, under the ACA. But there are inherent exposure risks to small group plan sponsors. We discovered strategic differences between plans offered by small and large firms through which small firms seek to mitigate risks (and therefore costs) based on employer propensities, plan design and benefits, financing, and risk management. About eight in 10 small firms choose to offer only one type of plan, usually a PPO. In contrast, large firms are likely to offer two or more plans and plan types. Smaller firms are more likely to offer a silver-tier plan which charges lower premiums but more in terms of employee cost-sharing. Some small firms offer only single employee-coverage plans, while none of the surveyed large firms do. Small firms also tend to subsidize family plans (if offered) at a lower rate, while their lower family premiums imply less generous health benefits on average. Small firms are much more likely to use fully-funded plans with higher deductibles to contain administrative overhead and transaction costs. And through brokers and agents, small firms tend to shop for new or better health insurance and/or carriers more often due to skyrocketing premiums. Premises considered, we generally find small firms to be more proactive in utilizing certain cost or risk mitigation approaches than their large counterparts.

Besides these approaches, we find communication through signaling an important aspect of small group provision. Within a small firm exists various levels, channels, and forms of communication: between owners and management in selecting healthcare coverage and making funding decisions; between plan sponsors and their brokers and agents in plan selection and price negotiation; between employers and employees, particularly during recruitment, open-enrollment, and qualifying life changes; and between plan sponsor, insurer, and government in terms of regulatory compliance. Efficient communication based on market signals provides information about options and alternatives to employer and employee alike relative to premium pricing and cost-sharing, design and scope of benefits, quality and levels of coverage, plan administration, claims adjudication, and legal and regulatory compliance, among others.

Communication between small firms (and working owners) is also crucial in deciding whether it is more cost-efficient to band together and establish AHPs. The associational route has helped small firms contain their financial and operational costs as a result of better predictability

of medical claims due to wider actuarial experience, greater leverage from higher insurer revenue generated from associational membership, and lower administrative expenses relative to volume of association enrollees. Many small groups had taken advantage of rather conflicting federal regulations that allowed them to set up large group AHPs prior to the ensuing federal litigation in 2019. On the one hand, the DOL's Pathway 2 permitted even unrelated and geographically distant small groups to associate and form AHPs which critics contended undermined commonalities of interest and reduced ACA risk pools needed for better experience rating and reasonable premium setting. On the other hand, combining the number of FTEs in associated small groups to gain insurer treatment as a large group plan could cause AHPs to lose (or evade) the enrollee protections mandated by the ACA to safeguard the market vulnerabilities of small firms and their comparative disadvantages relative to large firms.

Within and between small businesses, we find transaction cost reduction essential in administering and retaining employee healthcare coverage. Transaction costs pertain to those incurred in "doing business in the market," including search and information, bargaining and decision-making, and monitoring and compliance, in contrast to the costs of production and delivery (Williamson, 1979). Search and information alone can be quite burdensome, even with the use of brokers, agents, third-party administrators, and legal counsel for plan selection, administration, and pricing. Small firms have more limited income and other resources compared to large firms and many funding decisions about healthcare coverage bear directly on organizational viability. Lacking in risk pool size, actuarial experience, and negotiating leverage, small firms generally face higher bargaining and decision costs, while insurers have every incentive to raise premiums and cost-sharing, limit ("narrow down") provider networks, offer minimum or reduced benefits, etc., to minimize risk exposure in small group plans. Legal and regulatory compliance and monitoring can be just as challenging. Complex or conflicting federal and state regulations apply and are often uncoordinated, as exemplified by the AHP route. While ACA enacted small group healthcare reforms, insurance is under state jurisdiction and certain federal regulations might be implemented differently. The legal controversies surrounding small group associations and increasingly attractive large group-styled AHPs is once again illustrative. Therein also lies the paradox: The more flexible and convenient it becomes for small groups to associate and set up large group AHPs, the greater is the likelihood of undermining small group protections and standards under the ACA. As the DOL conceded, increased small group leniency under Pathway 2 introduces increased opportunities for mismanagement or abuse, in turn increasing oversight demands on federal and state regulators (DOL, 2018).

We thus find actuarial (or financial) risk helpful but rather narrow as an analytical framework for small group problem-solving and decision-making in health insurance. Because transaction costs abound, and are more challenging to small group healthcare coverage, transaction cost analysis is well suited in explaining why cost-inefficiencies arise and which plan design, options, and transactional arrangements might better minimize them.

Finally, whether it makes sense to retain, enhance, or replace, if not terminate, employer-sponsored health insurance will also depend on facts and circumstances attendant in a small firm. Business risk will vary by small firm depending on employee demographics, including age and wage distribution, firm size and productivity, budgetary and related considerations in employer

plan sponsorship, and competitiveness of insurance options and pricing. There are also trade-offs to consider in plan choices, alternatives, and approaches. A plan sponsor, for instance, may succeed in reducing cost with higher deductibles or through self-funding, but in a way that discourages take-up and increases employee preference for a compensating wage differential which could prove disadvantageous to small business owners. Be that as it may, this study has drawn attention to certain behavioral propensities of and strategic approaches available to small firms, and their business implications, which may be useful and timely in mitigating costs, risks, and trade-offs in employee healthcare coverage.

## CONFLICT OF INTEREST

The author has no relevant affiliations or financial involvement with any organization or entity with a financial interest in, or financial conflict with, the subject matter or materials discussed in the manuscript. This may include employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

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