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Trends, Challenges, and Options in Small Group Health Insurance

Most policy discussions about health insurance in the United States have considered large group health insurance and individual (or family) insurance coverage, while the small-group insurance market has been largely "neglected" (Hall and McCue 2018, p. 2).[1] For example, little effort has been made to understand the impact of the Affordable Care Act (ACA) (see **Box 1**) on the small-group insurance market.

A 2025 policy report by the National Federation of Independent Business (NFIB) suggests that the "small-group health insurance market is eroding, leading to higher costs and reduced options for small businesses." (National Federation of Independent Business 2025). Strikingly, they suggest that the small group insurance market is headed for "an inevitable collapse." The NFIB report also argues that the rising cost of health insurance is making U.S. small businesses less competitive.

An "inevitable collapse" of the small group market is arguably overstated. Still, the state of the small group health insurance market is a substantial concern for small employers and their employees and families, insurance regulators, and policymakers. In this report, we provide a primer on small group healthcare coverage. After providing some background and context, we turn to coverage options, trends, problems, and potential solutions.

Box1. The Affordable Care Act

The ACA plan was established by two laws: the Affordable Care Act (P.L. 111-148) and the Reconciliation Act P.L. 111-352). Expansion was to be achieved by creating marketplaces (health insurance exchanges), providing subsidies (in the form of tax credits), and expanding Medicaid. The ACA also introduced several consumer protections, such as prohibiting insurers from denying coverage for preexisting conditions and requiring essential health benefits.

As originally passed, the ACA required all states to expand Medicaid eligibility. The Supreme Court, in *National Federation of Independent Business v. Sebelius* (2012), upheld most of the ACA. However, the Court struck down the ACA's requirement that states expand Medicaid or risk losing all federal Medicaid funding.

(continues)

[1] Group health insurance provides coverage to a related cohort of people (usually employees of the same firm) under a single, shared policy.

1. Background

This section discusses different ways to define a "small business," the benefits of group coverage, the role of employer-sponsored health coverage in the United States, and a brief overview of the small group market before the ACA (the remainder of the report discusses the small group market in the context of the ACA).

1.1 Small Businesses

There is no single definition of "small business." The size threshold for a business depends on the source and the purpose of defining a small business. The Office of Advocacy at the U.S. Small Business Administration's (SBA) standard definition of a small business is "an independent business having fewer than 500 employees."[2] But the size that constitutes a "small business" may differ according to the firm's industry, as identified by the North American Industry Classification System (NAICS) code associated with that business.[3]

However, the Court struck down the ACA's requirement that states expand Medicaid or risk losing all federal Medicaid funding. As a result, Medicaid expansion became optional for states, leading to wide variation in coverage across the country initially. Since then, most states have adopted Medicaid expansion. For a state-by-state view of if and when each state expanded Medicaid, see KFF, Status of State Medicaid Expansion Decisions (last updated as of writing on September 25, 2025).

The ACA also sought to control costs and improve quality of care through payment reforms and preventive care requirements. The ACA originally included an individual mandate to obtain healthcare coverage or to otherwise pay a fee, which was treated as a tax. That mandate has since been eliminated by legislation.

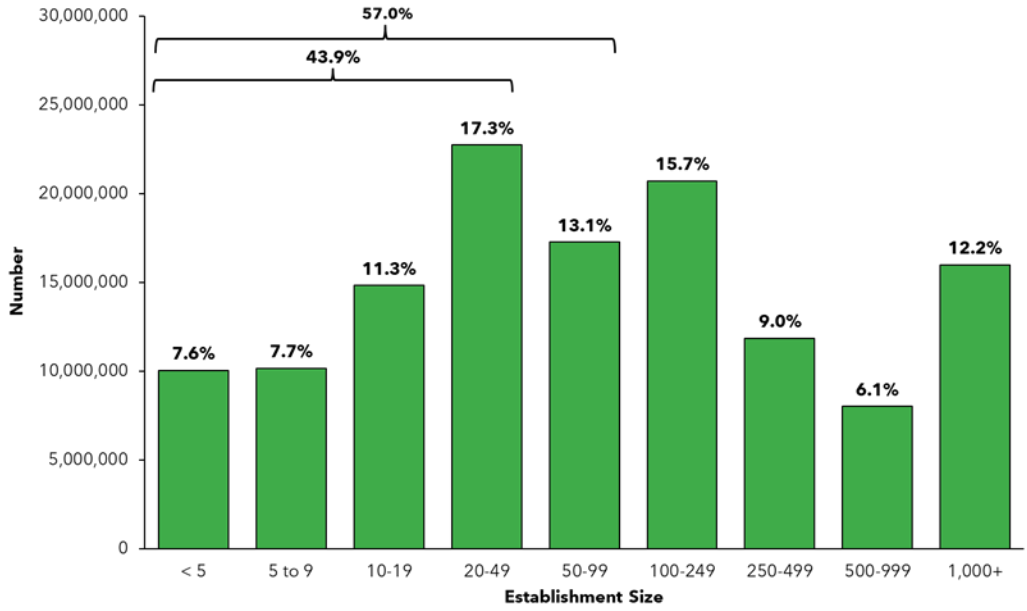
The 500 FTE threshold is intended by the SBA to establish eligibility for federal programs that support small businesses and is much larger than what makes sense as a threshold in the small group health insurance space. The Bureau of Labor Statistics (BLS) breaks down business size to as small as 1-4 employees in its statistics reported by establishment size.

By BLS accounting, most U.S. workers are employed by firms with fewer than 100 employees (**Figure 1**). Moreover, about 44% of U.S. workers are employed by firms with fewer than 50 employees. Smaller firms are not only the biggest employer in the United States, in aggregate, but also the primary job-creating machine (Edmiston 2007). For example, in the post-COVID-19 expansion (4th quarter 2019 – 4th quarter

[2] Office of Advocacy, U.S. Small Business Administration, "Frequently Asked Questions."
[3] For details, see the Code of Federal Regulations, Title 48, Chapter 1, Subchapter D, Part 19, Subpart 19.1 "Size Standards". For industry-level small business size standards used in government programs and contracting, see the Table of Size Standards.

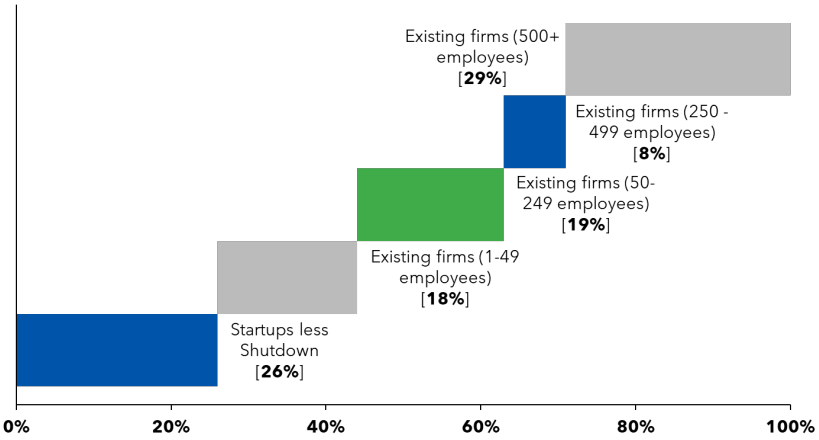
2023), almost half of all new jobs were created by start-up firms and firms with less than 50 employees (on net) (**Figure 2**).

Figure 1. Employment by Establishment Size



Source: U.S. Bureau of Labor Statistics

Figure 2. Job Creation by Firm Size



Source: U.S. Department of the Treasury

Notes: Firms may move categories from year to year. For example, a firm with 48 employees may have 55 the following year, putting it in a different category. Likewise, a firm could have an employment decline that moves it down a category. These movements could cause the chart to overestimate the share of jobs created by smaller firms, but differences are unlikely to meaningfully change the distribution. A "firm" is an entire company under common ownership. A firm may consist of several "establishments."

While small businesses are engines of growth, they face many hurdles. About 50% of new businesses do not survive in their first five years.[4] For businesses that fail, 82% do so because of cash flow issues.[5] Unsurprisingly, the most substantial cost for small businesses is labor—wages, salaries, and benefits—accounting for as much as 70% of total cost.[6] Much of the increase in labor costs over the last several years has been a rise in the employer cost of health insurance (See Section 4.1).

Given that 44% of workers are employed by firms with less than 50 employees (and an additional 13% by firms with 50-99 employees), better health insurance options for small firms would mean more affordable health insurance for a large segment of the working population and their families. Moreover, nearly two-thirds of new jobs are provided by start-up firms, which are often exceptionally small employers but are often the most innovative and dynamic, and existing small firms, which also contribute significantly to the dynamism of the U.S. economy. These firms need lucrative benefit options to attract the right employees to push innovation and dynamism going forward.

1.2 Group Health Insurance Coverage

Group health coverage is a type of health coverage that is offered to a defined cohort, usually employees of a company, but possibly members of a union, association, or other organization. Instead of individuals buying separate policies, the group purchases one master contract (or they self-insure), and members receive coverage under that one policy.[7] In the alternative, private insurance is purchased directly from an insurer, often with the assistance of an insurance agent or through an online platform (e.g., Healthcare.gov). This type of private insurance is "individual" or "non-group" health insurance.[8]

A substantial benefit of group health insurance coverage is that it mitigates adverse selection. Adverse selection occurs because people who expect to have the greatest need for health insurance; that is, the greatest expected medical costs, are more likely to purchase coverage (or more comprehensive coverage) and will be more willing to pay higher prices than healthier people with low expected medical costs. Because the

[4] An often-cited figure is that 95% of small businesses fail within the first five years, but that number has been debunked by several credible sources. See, e.g., Liam Austin, "Small Business Statistics 2025 Report: Growth, Revenue & Trends," entrepreneursHQ, June 13, 2025. See also Timothy Carter, "The True Failure Rate of Small Businesses," *Entrepreneur*, January 3, 2021. If failure to meet projections is the indicator, then the 95% figure is accurate (U.S. Bureau of Labor Statistics).
[5] Austin, 2025.
[6] Paycor, "The Biggest Cost of Doing Business: A Closer Look at Labor Costs," December 18, 2024.
[7] The different healthcare coverage types, which include fully insured and self-funded plans, are discussed in Section 2 of the report.
[8] See Claxton, Rae, and Winger (2025).

risk pool would naturally end up with a disproportionate number of high-cost individuals, premiums would rise, which could push even more healthy people out, potentially destabilizing the health insurance market. Ostensibly, employees join the group primarily for employment, not health insurance. Therefore, the risk pool is likely to be much healthier and more predictable. All else equal, group plans minimize adverse selection.

In addition to reducing adverse selection, group health insurance is popular because there is no individual underwriting and lower marketing costs and administrative costs are lower; individuals who would likely fail a medical test in the underwriting of an individual plan can still get coverage; employer contributions are deductible and employees are not taxed on the employer contributions either (Cogan Jr. 2018).

Small group health insurance refers to employer health insurance coverage when the employer is a small business, particularly a "small employer." A small employer for the purposes of the ACA has less than 50 employees, although that number has been expanded to 100 in a few states (e.g., California, Colorado, New York, and Vermont).

The regulatory requirements for small and large group markets differ in some ways. Generally, the small group insurance market is subject to more extensive rules about benefits and ratings.[9]

1.3 Employer-Sponsored Health Insurance

Although the U.S. healthcare system is a hybrid of private and public health coverage, it is distinguished by its reliance on employers to offer healthcare benefits to their employees voluntarily.[10] The United States was the first country to establish a largely employer-based system of providing insurance (Edmiston 2025). During World War II, emergency economic measures to support the war effort prevented companies from increasing wages. Given the ingenuity of American companies, they found a way around this restriction, offering fringe benefits in place of wage increases. The key fringe benefit was health insurance.

As part of his "Fair Deal" agenda following the war, President Truman proposed a compulsory national insurance system, which was defeated in Congress. This defeat laid the groundwork for the present-day system in the United States, where insurance for those under 65 is largely employer sponsored.

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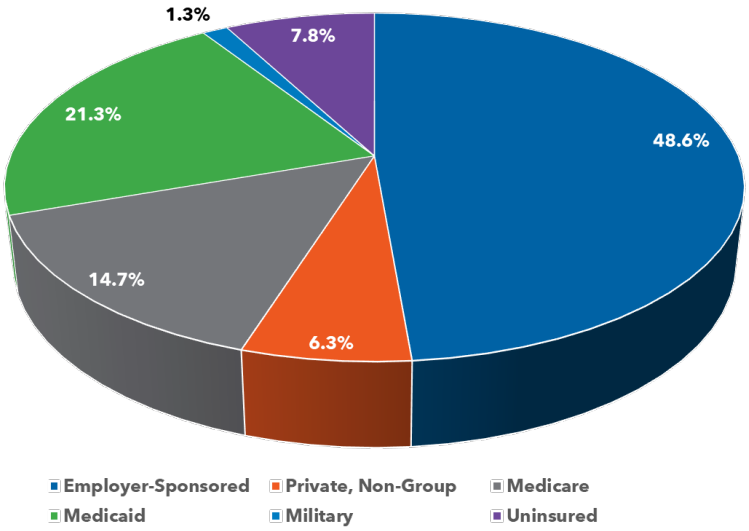
[9] Rating determines how much an individual or group pays in premiums, based on allowed characteristics.

[10] The emphasis is on "voluntarily." There are other countries with healthcare systems that are universal but largely provided through employers (see Tulchinsky and Varavikova 2014). Examples include Germany, France, and Japan. The United States is the only OECD nation without universal coverage.

The U.S. relies on voluntary, private health insurance as the primary source of coverage for residents who are not elderly, poor, or disabled (including those with non-employer private coverage) (Claxton, Rae, and Winger 2025). Employer-sponsored health insurance is the largest single source of healthcare coverage for non-elderly U.S. residents (including dependents of the workers on employer plans). Roughly half of U.S. residents under age 65, or about 158.4 million people, had employer-sponsored health insurance in 2023 (**Figure 3**).

Figure 3. Health Insurance Coverage of the U.S. Population, 2023



Source: KFF, "Health Insurance Coverage of the Total Population"
Data Source: American Community Survey
Note: Dually eligible beneficiaries (Medicare + Medicaid) are counted as Medicaid. If they were counted as Medicare instead, the number with Medicare would increase by 3.3 percentage points, and the number with Medicaid would decrease by 3 percentage points.

The BLS Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) puts the share of the non-elderly population covered by employer-sponsored health insurance at 60.4% in 2023. The greater value for the CPS ASEC is due largely to the specific survey question that is asked. While the ACS asks if the respondent is insured *at the time of the interview* (a point-in-time measure), the CPS ASEC asks if the respondent was covered by health insurance *at any time during the past year*.[11]

[11] There are other differences in the surveys as well. The ACS, which samples 20% of the U.S. resident population every year, is a much larger sample than the CPS, which surveys about 60,000 households monthly. Further, the two surveys are designed for different purposes. The CPS ASEC is designed for (more frequent) national statistics, while the ACS is designed to be used for small area sample estimates, which is made possible by its large sample size. Although the KFF data documented in

Of those who are eligible for health insurance provided by their employer, 74.4% take the coverage. The level of health insurance coverage varies significantly with income and other socioeconomic and demographic factors, even among working families (Claxton, Rae, and Winger). According to the CPS ASEC 23.9% of those with incomes below 200% of the federal poverty line (FPL) had employer-provided coverage in 2023, compared with roughly 84.2% of those with incomes at 400% of the FPL or above (Claxton, Rae, and Winger).[12] This result is not surprising considering that in most states (which have expanded Medicaid), most of those with incomes below the 200% of the FPL would qualify for Medicaid. Moreover, those with lower incomes are more likely to be employed part time, and part-time workers are significantly less likely to be covered by employer-sponsored health insurance. While 81% of full-time employees are eligible for healthcare coverage at their job, only 38.4% of part-time employees are eligible.

Although the offer of health benefits by small employers has been declining (Section 1.6), and there are now more individual options available, several advantages of offering health insurance coverage remain for small employers and their employees. Health insurance is an expected and important benefit for most employees and job seekers. Small employers must compete with large firms for this talent, both in filling job openings and in retaining current employees. Health insurance is perhaps the most critical component of a competitive compensation package. In a 2023 survey, 63% of small employers reported that offering health insurance to recruit and retain employees is "very important" or "moderately important."[13] Some small employers may receive tax savings that can offset some of the cost of providing health insurance. Premiums paid by the employer are tax-deductible as a business expense. Moreover, plans purchased through the Small Business Health Options Program (SHOP) may qualify for the federal Small Business Health Care Tax Credit.[14]

Outside of attracting and retaining employees, the most significant benefit of small-group (or large-group) health insurance is risk pooling. By definition, small employers do not have many employees. Thus, if insuring each employee individually, one employee's high medical costs could be financially devastating. Small-group plans combine all employees into one risk pool, spreading costs more evenly. Small-group

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Figure 3 are 1-year estimates, the Census Bureau also provides 3-year and 5-year averages from the ACS for more geographically granular analysis.

[12] These numbers were adjusted downward to reflect the difference in the percentage of the population that is employer-covered between the ACS (48.6%) and the CPS (60.4%).

[13] NFIB Research Center, "Small Business Health Insurance Survey," March 2023.

[14] We discuss SHOP and the federal tax credit in more detail in Section 3.1 of the report.

health insurance allows small businesses to buy standardized, regulated plans—often at lower prices than individual employees could get on their own.

1.4 Small Group Health Insurance Before the Affordable Care Act

Small group health insurance has a long but tumultuous history in the United States. Before the ACA, the small group health insurance market operated under a patchwork of federal and state regulations, with significant variations across states. Federal laws like the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided some protection, such as guaranteed issue for small groups, but the market was largely characterized by limited affordability, risk-based underwriting, and declining participation.[15]

Efforts by small businesses to provide health insurance for their employees were further hampered by carrier restrictions intended to encourage wide employee participation, which could assure a stable risk pool.[16] Examples of these restrictions include minimum employee participation (e.g., 60% enrollment) and minimum employer contributions (e.g., 50% of premiums). Additionally, when plans were made available, premium pricing in the small group market relied heavily on medical underwriting and experience rating, where insurers assessed risks based on group health status, claims history, age, industry, and other factors. This approach to underwriting led to more volatile and higher costs. For example, a single employee health event could spike premiums for the entire group. **Table 1** summarizes major differences between pre-ACA rules and regulations and post-ACA rules and regulations.

Nationally, small firms were less likely to offer health insurance compared to larger employers, and fewer small employers offered insurance plans over time. In 1989, 41% of small firms (fewer than 50 employees) provided health insurance to their employees, which dropped to 34% by 1991 (KFF 1997). The drop in offer rates and enrollment before the ACA came into effect was steeper for very small firms (fewer than 10 employees) and low-wage businesses, where part-time workers and lower

[15] "Guaranteed issue" means that (in this case) small firms cannot be denied group coverage based on the health status or claims experience of their workers. Sole proprietors without common-law employees did not qualify. A worker is a common-law employee if the employer has the right to direct and control the worker's performance. That is, the employer can dictate how, when, and where the work is performed. See IRS, "Employee (common-law employee)." Guaranteed issue applies to large firms as well (but there is less of a problem with qualification, given the large risk pool). Following the ACA, individuals are also guaranteed coverage.

[16] California Healthcare Foundation, "Health Reform in Translation: Small Group Coverage Before and After the ACA," August 2013.

incomes reduced demand for employer-sponsored insurance (Banthin and Grazevich 2022).

Table 1. Market Rules for Private Health Insurance Sold to Small Groups

Market Rule	Pre-ACA	Post-ACA
Guaranteed issue	Yes	Yes
Rating based on health status is prohibited	No	Yes
Gender rating prohibited	No	Yes
Discrimination between groups is prohibited	Yes	Yes
Pre-existing exclusions prohibited	No	Yes
Pre-existing exclusions limited to 12 months with credit for prior coverage	Yes	NA
Guaranteed renewability required	Yes	Yes
Recissions permitted	No	Yes

Source: Ortaliza, McGough, and Cox (2025)
Notes: For fully funded plans. ACA-compliant health plans sold on the small group market can only vary premiums based on location (community rating), family size, tobacco use, and age.

Before the ACA, variability in insurance premiums posed significant challenges, often deterring employers from offering insurance entirely. Surveys at the time indicate that approximately 75 percent of small employers that did not provide health insurance cited high premium variability as the primary reason for their decision (Kapur 2004; Morrisey, Jensen, and Morlock 1994).

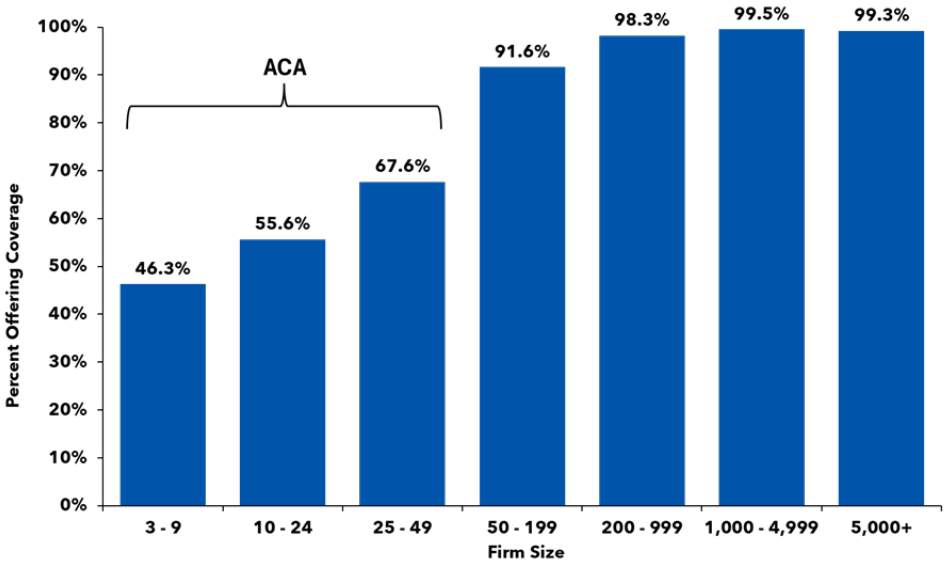
Between 1989 and 1995, 45 states enacted legislation to make small group health insurance more accessible and attractive (KFF 1997). The small group market was targeted for reform because roughly half of the uninsured population was either self-employed or working in a firm with fewer than 25 employees.

1.5 Trends in Small Group Health Insurance Coverage

Small-group health insurance exists to give employers and employees access to more affordable, more stable, and usually better coverage than they could typically get individually.[17] Providing health insurance to employees is much more challenging for small firms than for large firms. Insurance is typically more costly, the smaller the pool, because the objective risk is so much higher. KFF provides a granular view of the likelihood of receiving employer-provided insurance by firm size, as measured by the number of employees (**Figure 4**). The share of employers that offer health insurance to their employees increases steadily with the number of employees

[17] Employers may purchase a health insurance policy from a state-licensed health insurer, in which case we say the employer is "fully insured." Alternatively, the employer can pay for healthcare for the plan enrollees directly with its own assets, in which case we say the employer is "self-funded." Types of healthcare coverage are described in Section 2.

Figure 4. Employer Health Insurance by Firm Size, 2024



Source: KFF, 2024 Employer Benefits Survey
Notes: The 2025 survey does not break down firm size to this degree, as the smallest firm size considered is 10.

Arguably, the importance of small group plans has diminished since the ACA came into effect, as subsidized, more regulated health insurance is accessible to individuals. However, a decline in the offer of health benefits by small employers preceded the ACA (the exchanges became operational in 2014).[18] These data can be viewed at both the firm level and the establishment level. A "firm" is an entire company under common ownership. An establishment is a single physical location where business is conducted. A firm may consist of several establishments.

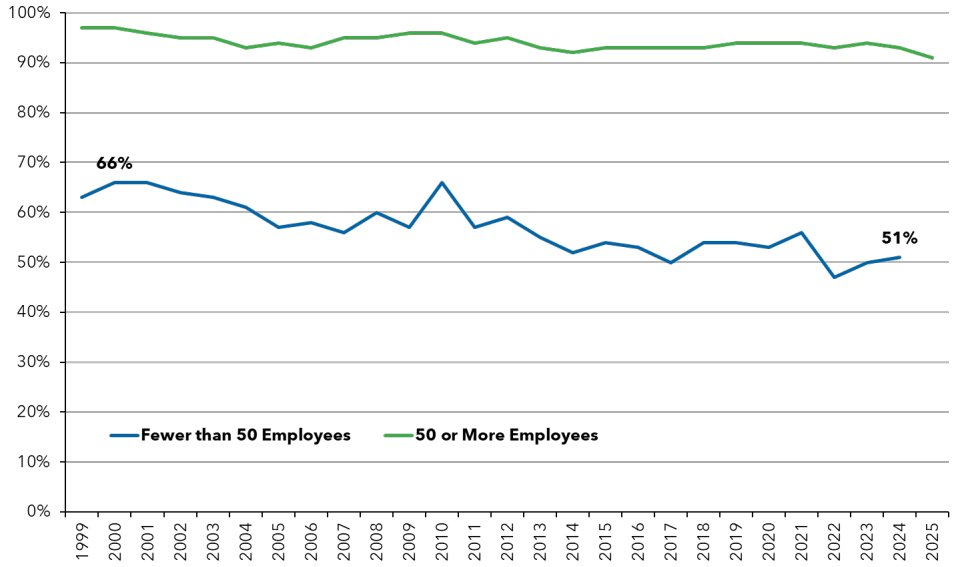
The share of small firms offering health insurance coverage (fewer than 50 employees) fell from 66% in 1999 to 51% in 2024 (**Figure 5**).[19] The share of firms with 50 or more employees offering health coverage has remained relatively stable over time at between 95% and 97%.

The KFF Employer Health Benefits Survey queries businesses at the firm level. Another commonly used survey, the Medical Expenditure Panel Survey Insurance Component (MEPS-IC), which is administered by the Agency for Healthcare Research and Quality (AHRQ), queries businesses at the establishment level. In so doing, they

[18] KFF notes that offer rates among small employers can vary widely from year to year (2024 Employer Health Benefits Survey, Summary of Findings).
[19] With the 2025 survey, KFF began reporting data from firms with 10 or more employees only. Thus, their 2025 value is not comparable to previous periods.

find much lower rates of employer-sponsored health insurance offers than KFF finds at the firm level. The reason is that a firm is often an amalgamation of establishments. One might imagine a firm that consists of 5 establishments, none of which offers health insurance coverage. If one of these establishments begins to offer coverage, then the firm is deemed to offer coverage, although the four remaining establishments do not offer coverage. If measured at the firm level, firm employees will be considered to have access to employer-provided health insurance, but if measured at the establishment level, only a fraction of the firm's employees would be considered to have coverage offered.

Figure 5. Firms Offering Health Coverage, By Employment Level, 1999 – 2024



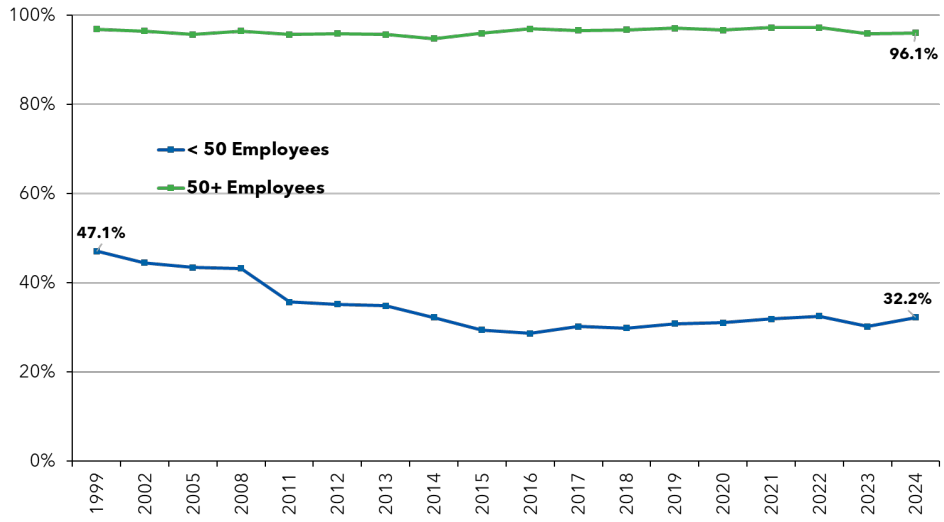
Source: KFF, Employer Health Benefit Surveys, various years
Note: The unit of analysis in the KFF survey is a "firm," which is an entire company under common ownership. A firm may consist of several establishments.

The MEPS-IC data show much less access to employer coverage for small businesses than does the equivalent KFF data in Figure 4. In 1999, 47.1 percent of employees worked at establishments offering health insurance, which fell by nearly one-third to 32.2% by 2024 (**Figure 6**).

Meiselbach and Abraham (2025) examined MEPS-IC data and found that only in Hawaii, which has an employer mandate, did more than 50% of small employers offer employee health insurance in 2022-2023 and that in 10 states, fewer than 25% of small employers offered health insurance coverage to their employees. Their data show that virtually every state has seen a "substantial" decline in the percentage of

small employers that offer health insurance since 2002, 35 states exceeding 10 percentage points in decline, and six states exceeding 20 percentage points.

Figure 6. Establishments Offering Health Coverage, By Employment Level 1999 – 2024



Source: MEPS-IC

Data in a 2025 report by JPMorganChase show that in the pre-pandemic period (2018-2019), nearly one-third of small businesses stopped providing health insurance.[20] Little of the discontinuation was due to firms becoming inactive, as most remained in business

Perhaps the greatest challenge to small businesses in recent years has been the high cost of providing health insurance to their workers (see Section 4.1). Survey evidence suggests that the high and increasing cost of health insurance for small employers may be driving the declines notes by Meiselbach and Abraham (2025). According to a 2024 Thatch survey, 93% of small business employers are concerned about the sustainability of their employee benefit plans (Wolf and Stevenson 2024).[21] Of these, 36% say "overall affordability" is the top challenge, followed by "high premiums" and "high administrative costs." Meanwhile, the same survey shows that 73 percent of small businesses feel competitive benefits are "important for business survival."

[20] JPMorganChase, "The Consistency of Health Insurance Coverage in Small Businesses: Industry Challenges and Insights," April 10, 2025.
[21] Thatch is a health benefits provider/consultant for employers.

2. Health Coverage Options for Small Employers

The small group health insurance market has undergone a significant transformation over the past decade. In response to evolving regulatory landscapes, changing workforce needs, and ongoing pressures to manage costs, small employers are increasingly exploring a variety of coverage arrangements beyond traditional fully insured plans. This section provides an overview of the main types of health benefit arrangements available to small businesses and their defining features, regulatory context, advantages, and limitations.

2.1 Fully Insured Plans

A fully insured health insurance plan is the traditional model of employer-sponsored healthcare coverage. The employer pays a fixed premium to an insurance carrier, and the insurance carrier pays all covered medical claims for employees and their dependents.[22] The insurer assumes all the financial risk of unexpectedly high claims. These are the plans most people think of as "health insurance."

Fully insured plans have several benefits for small businesses. The first is predictable cost. The employer knows exactly what it will pay for employee health coverage (the premiums). The second is risk transfer. The financial risk of unanticipated high claims is transferred from the employer to the insurer. Finally, administration is likely to be simpler for the employer.

2.1.1 Trends in Fully Insured Plans for Small Businesses

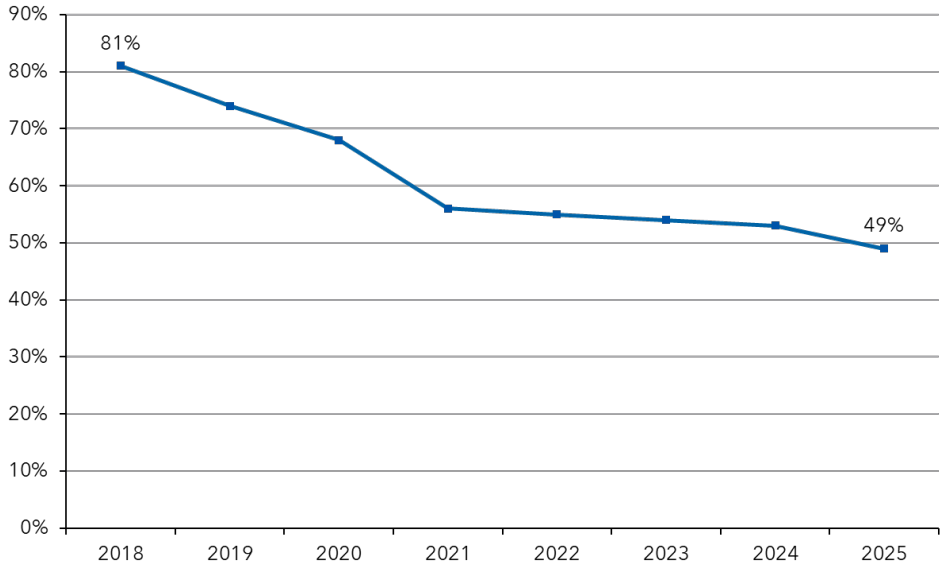
About half of small employers that provide health insurance offer fully insured plans, or more, depending on how "small" is defined. For employers with 10-49 workers, 56% of covered workers were enrolled in a fully insured plan in 2025 (Claxton et al. 2025). For firms with 50-199 workers, the percentage drops to 43%. But over the last several years, the percentage of covered workers at small employers (fewer than 200 employees) in a fully insured plan has declined substantially (**Figure 7**). The explanation is largely small businesses switching to self-funded or especially level-funded health plans (Section 2.2).

Fully insured plans are largely regulated by the states; however, some federal policies apply, the most salient being the ACA. Many states enforce the ACA, while in some states, the ACA is enforced by the federal Centers for Medicare and Medicaid Services (CMS). States can and do have their own regulations for fully insured plans, some of which override components of the ACA. However, these regulations are

[22] Employers typically charge employees for some portion of the premium, usually by payroll deduction.

required by federal law to be at least as strict as the ACA requirements. Some states, for example, have stricter network adequacy requirements than the ACA.[23]

Figure 7. Percentage of Covered Workers at Small Firms in a Fully Insured Plan



Source: CIPR analysis of data from the 2025 KFF Employer Benefits Survey.
Note: Firms with fewer than 200 employees.

State insurance regulations, including benefit mandates, could affect the type of insurance coverage provided by small employers and whether small employers decide to offer coverage at all. As noted above, Meiselbach and Abraham (2025) find significant variation across states in the share of small employers offering employee health insurance coverage. They suggest this variation is due, at least in part, to differences in policies and market conditions.

2.1.2 Small Group (Full) Insurance Under the ACA

Before the ACA, the primary federal law governing health insurance was HIPAA (1996).[24] HIPAA provided guaranteed issue and guaranteed renewability for all group

[23] In the healthcare context, a network is a group of physicians, hospitals, and other healthcare professionals and facilities that have contracted with a health insurance plan to provide medical services at negotiated (usually lower) rates. Network Adequacy refers to a health plan's ability to provide reasonable access to a sufficient number of healthcare providers and facilities, ensuring that plan members can access covered benefits within a reasonable distance and with reasonable wait times. The ACA also mandates that health plans in Marketplaces meet additional network adequacy criteria such as sufficient provider choice, inclusion of essential community providers, and transparency in provider availability.

[24] Fully funded health insurance is largely regulated by the states, but there are federal rules, like HIPAA and the ACA, to which insurers must comply. The exception is self-funded plans, which are governed largely by federal law, specifically, the Employee Retirement Income Security Act of 1974 (ERISA). Self-funded plans vis-à-vis other types of plans are covered in detail in Section 2.2.

plans. Guaranteed renewability ensured that insurance carriers could not refuse to renew a group plan because employees became sick. HIPAA also put some limits on preexisting condition exclusions (not for individual insurance plans). Limits were allowed, but they were capped, and creditable coverage rules applied.

Several market reforms in the ACA affect small businesses in significant ways. For the ACA, a small employer is defined as one with fewer than 50 full-time equivalent employees (FTEs), although a few states have expanded the small business threshold to 100 FTEs. The "employee" must not be the owner of the business or his/her spouse. These plans allow small businesses to provide health insurance coverage to their employees and, at their discretion, to employees' dependents.

Under the ACA, all small group health plans must comply with specific regulatory standards. First, workers who purchase small-group health insurance are provided substantially more consumer protection than they had before. Among the most important is the guarantee that preexisting medical conditions can no longer preempt coverage or result in higher premiums. Perhaps equally important, these requirements included guaranteed issue, meaning coverage must be offered to group plans without regard to the health status of a firm's employees and guaranteed renewability.

Also critical was the imposition of community rating, which means that approval and premium rates are determined only by geography (hence, "community") and age.[25] The only other risk factor that can be considered is smoking, which is entered into the rating calculus in some states but not in others.

In addition, all health insurers in the small group (and individual) markets must cover an identical, comprehensive set of benefits known as the Essential Health Benefits (EHBs) or Minimum Essential Coverage (MEC). EHBs were designed to ensure that consumers are able to access comprehensive coverage, but also to prevent insurers from avoiding high-risk enrollees by designing plans that appeal only to healthy, low-cost beneficiaries.

Congress did not statutorily define the full package of benefits, instead delegating primary authority for that task to the Department of Health & Human Services (HHS). Monahan (2018) argues that HHS has implemented the EHB requirements in a manner that "appears structurally incapable of achieving the goals of the statute" by using a vague definition of benefits, allowing benefit substitutions, and failing to limit use of service-level selection tools, which has permitted insurers to compete for low-

[25] Older beneficiaries may not be charged more than three times the rate of younger beneficiaries.

risk insureds, avoid paying for certain high-cost treatments, and prevented consumers from making fully informed purchasing decisions.

An important mechanism for improving the accessibility and affordability of health insurance for small businesses (and individuals) was the establishment of health insurance exchanges, called "Marketplaces," where small employers could purchase qualified health insurance plans (QHPs), choosing from a broader selection of healthcare plans while potentially lowering premiums due to increased competition and regulatory requirements (Kapur et al. 2011; Giaimo 2013). The ACA Marketplaces are for small employers that are fully insured, which are regulated by the states (self-insured plans are regulated under ERISA).

The ACA provides a Small Business Health Care Tax Credit intended to help small businesses afford employee health insurance. The credit is worth up to 50% of the costs paid for premiums (35% for non-profit employers). There are several restrictions associated with this tax credit. Among these, the employer must have fewer than 25 FTEs with an average salary of $56,000 annually or less (indexed to inflation; $65,000 for 2025).[26] The employer must pay at least 50% of health insurance premiums for full-time employees. Finally, coverage must be obtained from the Small Business Health Options Program (SHOP) Marketplace, where it is available.

The ACA, as initially passed and implemented, included an individual mandate, which required individuals to carry healthcare coverage or else pay a significant penalty to the IRS. The penalty was reduced to zero during the first Trump Administration (2019) and eventually eliminated. Small employers (again, defined as fewer than 50 FTE) were never mandated to provide healthcare coverage to their employees, but large employers were required to provide coverage meeting specific criteria or else pay penalties (Shared Responsibility Payments) to the IRS, which could be severe.

There were myriad changes at the individual level, as well, which benefit workers at small businesses who do not have access to employer coverage (Hall and McCue 2018) (see **Box 2**, next page). These changes included many of the same changes that were made at the group level, such as prohibition against pre-existing condition exclusions and requirements to provide EHBs. Perhaps most importantly, the ACA provides for generous subsidies, the level of which is dependent on income, along with reduced cost-sharing.

[26] Seasonal workers are not counted unless they work 120 or more days annually.

Box 2. Subsidies in the Individual Marketplace

In the individual health insurance market, premiums can be prohibitively expensive to the insureds in the absence of financial assistance. To address this affordability barrier, health insurance subsidies were established to reduce both monthly premiums and out-of-pocket costs for eligible individuals and families. By improving affordability, these subsidies aim to increase enrollment, attract healthier individuals to the risk pool, and expand access to care, each of which is essential to maintaining a stable and equitable individual market.

Two primary mechanisms exist in this space: premium tax credits (PTCs) and cost-sharing reductions (CSRs). PTCs are income-based subsidies that lower the cost of premiums for plans purchased through the ACA marketplaces. CSRs lower out-of-pocket expenditures, including deductibles, copayments, and coinsurance, for low-income individuals, typically those with household incomes between 100% and 250% of the FPL, who enroll in silver-tier marketplace plans.

Under the original ACA framework, eligibility for PTCs was limited to individuals with household incomes between 100% and 400% of the federal poverty level (FPL). However, the American Rescue Plan Act (2021) and the Inflation Reduction Act (2022) temporarily expanded eligibility beyond 400% FPL by capping individuals' premium contributions at 8.5% of income, thereby increasing subsidy generosity and broadening access to subsidized coverage.

Unlike PTCs, CSR benefits are not disbursed directly to enrollees. Instead, insurers are required to apply reduced cost-sharing at the point of service. A major shift in the financing of CSRs occurred in 2017. Until October of that year, the federal government reimbursed insurers for the additional costs associated with providing CSRs. However, following a legal challenge and a subsequent administrative decision under the Trump Administration, reimbursement payments were terminated on the grounds that they lacked explicit congressional appropriation.

Although the CSR benefits themselves remained in place, insurers were compelled to absorb the financial burden. To offset these losses, insurers adopted a pricing strategy known as "silver loading", whereby they increased premiums specifically for silver-tier plans. Because PTCs are calculated based on the cost of the second-lowest-priced silver plan in a given rating area, silver loading resulted in higher premium tax credit amounts for eligible enrollees. Consequently, although direct federal payments for CSRs ceased, the federal government continued to bear the cost indirectly through increased PTC expenditures. This shift has important implications for federal spending, market pricing dynamics, and policy debates concerning subsidy design and fiscal sustainability.

SHOP platforms were originally established under the ACA to provide small employers with streamlined access to ACA-compliant plans and eligibility for the Small Business Health Care Tax Credit. However, from its inception, SHOP enrollment lagged and never truly gained significant traction. Challenges included difficulties attracting insurers willing to offer small group plans on the Marketplace, the limited number of states that implemented a SHOP component within their state-based exchanges, the restricted functionality of SHOP platforms, and the narrow criteria for tax credit eligibility. In practice, many small employers obtain comparable ACA-compliant plans outside the public exchanges directly from insurance carriers or licensed brokers.

Historically, the majority of small employers have opted for fully insured health plans. However, rising premiums and the increasing desire for flexibility have prompted a gradual shift in the small group market, as employers increasingly explore alternative arrangements, including self-funded plans, level-funded plans, Health Reimbursement Arrangements (HRAs), or, in some cases, discontinuing coverage altogether. Many of these alternatives fall outside the ACA Marketplace Exchanges, further contributing to the declining use of exchange-based small group plans in recent years.

2.2 Self-Funded Plans

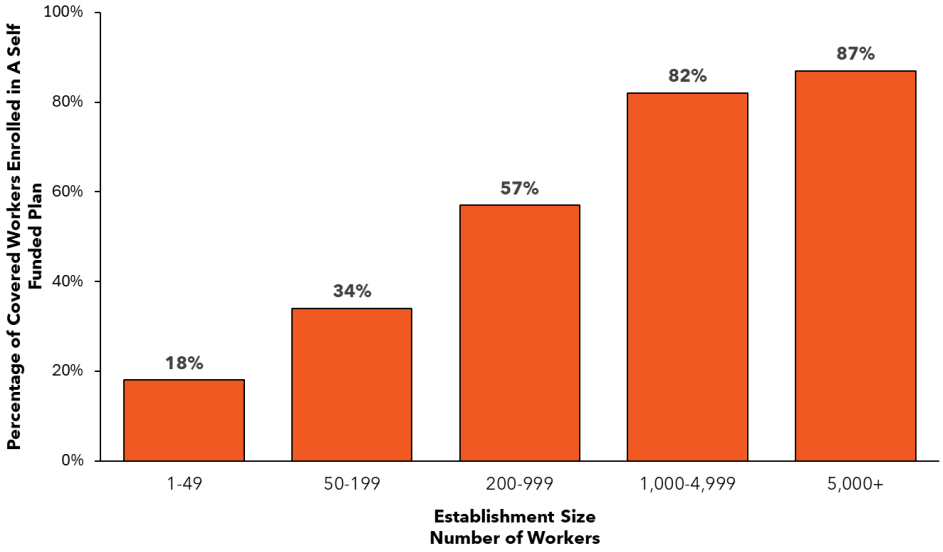
Rather than pay a fixed premium to an insurance carrier for a fully insured plan, employers with self-funded plans pay for claims using their own financial resources. The level of claims being uncertain, the employer bears the financial risk of especially large, unanticipated claims.

Employers with self-funded plans typically purchase stop-loss coverage to mitigate this tail risk (discussed in more detail later in the report). Under a stop-loss policy, a contracted insurer is liable for losses that exceed specified thresholds. These predetermined amounts are known as attachment points. Stop-loss coverage provides reimbursement to self-funded employers for claims costs that exceed the attachment points.

Typically, firms with self-funded plans use a third-party administrator (TPA)—often a health insurance company—for networks, claims processing, and customer service. Beneficiaries are unlikely to recognize that their plan is self-funded. *To the beneficiary*, self-funded plans look like traditional health insurance plans and are administered in much the same way. Employees who are offered a choice among plans do not "choose" a self-insured plan (which is an employer decision), but rather, they choose the type of coverage they want, given the plans offered. All types of plans (i.e., PPO,

EPO, POS, and HMO plans) can be financed on a self-funded basis.[27] Self-funded plans are relatively rare in small business cases, ostensibly due to the much greater risk that comes with a small pool of insureds. In 2025, 18% of employers with less than 50 employees provided health coverage that was self-funded (**Figure 8**). By contrast 87% of employers with over 5,000 employees provided self-funded health coverage. However, small businesses are increasingly opting for *level-funded* health insurance, which is a hybrid between fully insured and self-funded models.

Figure 8. Enrollment in Traditional Self-Funded Plans by Establishment Size



Source: KFF, 2025 Employer Health Benefits Survey
Note: This figure reflects enrollment in traditional self-funded plans and does not include enrollment in level-funded plans, which are described below.

2.2.1 Traditional Self-Funded Plans

While fully insured plans are largely state-regulated, self-funded plans are largely governed by the Employee Retirement Income Security Act of 1974 (ERISA), which sets minimum standards for most private sector employer-sponsored health (and retirement) plans. The exception is stop-loss coverage. Stop-loss is regulated as "insurance," over which the states have authority. States can determine when stop-loss coverage is considered "insurance," set minimum and aggregate attachment points, and regulate marketing practices and financial solvency (of the insurers offering stop-loss).

[27] PPO and EPO refer to preferred-provider and exclusive-provider organizations, respectively. POS refers to point-of-service plans. HMO refers to health maintenance organization. For detailed explanations, see Polsky and Weiner (2015).

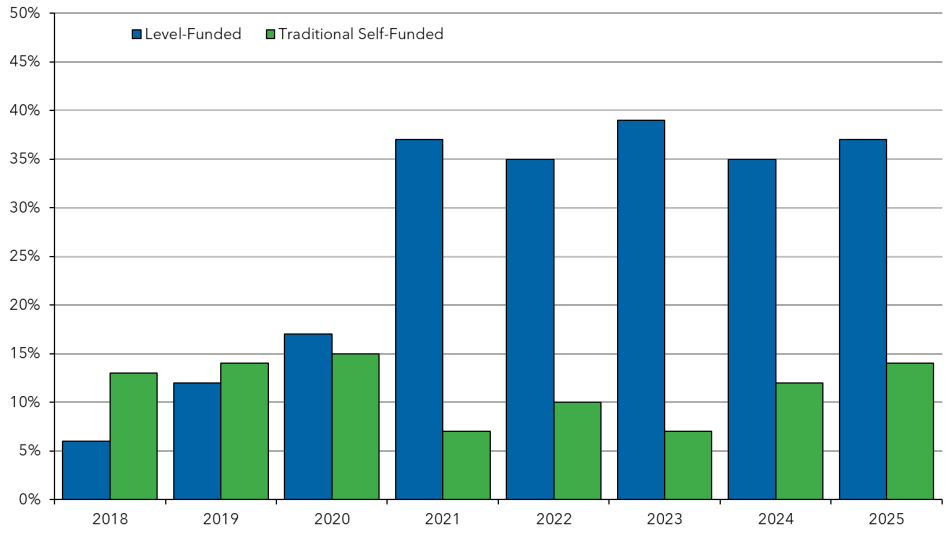
Many states restrict the sale of stop-loss with low attachment points to small groups (usually fewer than 50 employees) to prevent insurers from avoiding small-group regulated markets. Others disallow aggregate stop-loss or require minimum aggregate attachment points (e.g., 120% of expected claims). For example, some states, such as California and New York, have put limitations on the issuance of stop-loss policies for small employers specifically, making self-funding considerably riskier for this group (Meiselbach and Abraham 2025). While these regulations aim to uphold the integrity of the small group insurance market, they have also contributed to a decline in the rate at which small employers offer health insurance.

Both the likelihood that a self-funded employer purchases stop-loss coverage and the size of attachment points vary widely based on employer risk tolerance, financial capacity, and firm size. Smaller employers often choose lower attachment points to limit potential liabilities, resulting in higher per-employee premiums, whereas larger employers typically select higher attachment points due to their ability to better absorb large losses and take greater risks. Larger employers are also much more likely to purchase stop-loss coverage than small employers: 92.6% of businesses with 100 to 999 employees report having stop-loss coverage, compared to only 21.1% of businesses with fewer than 10 employees (Employee Benefit Research Institute, 2024). While most large employers rely on stop-loss coverage, a small number of the largest employers with sophisticated risk management capabilities may self-insure without protection from stop-loss coverage or a captive.

2.2.2 Level-Funded Plans

Level-funded plans are a form of self-funding in which employers make predictable monthly payments (fixed monthly premiums) that bundle the expected cost of claims, stop-loss insurance premiums, and administrative fees. Level-funded plans generally include surplus refunds or credits if claims are lower than expected, whereas this is not a standard feature of traditional self-funded plans. As more and more employers are priced out of the fully insured market and look for more affordable options, level-funded plans are proliferating to meet this need (**Figure 9**), creating a dynamic insurance market that would save money for small employers while benefiting taxpayers and the economy (Talento et al., 2023).

Figure 9. Small Businesses with Self-Funded and Level Funded Plans



Source: KFF, 2025 Employer Health Benefits Survey
Note: "Small firms" in this chart are those with 10-199 employees.

Level-funded plans are generally subject to ERISA regulations, except in the case of government and church plans. Government and church plans are non-ERISA plans, and therefore ERISA does not apply. Some states can regulate stop-loss insurance.[28] In rare cases, if an employer states that it is self-funded, but the state in which it is located deems the plan to actually be *level-funded* or improperly structured, then at least some state regulations may apply.[29] Moreover, states may have some authority over Multiple Employer Welfare Arrangements (MEWAs) (discussed below) when certain conditions are met.[30]

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[28] See, for example: California Insurance Code §10752 (2025), Minnesota Stat. §60A.235, Oregon Rev. Stat. § 742.065, and Delaware Reg. 1322, all of which restrict attachment points on stop-loss plans. See also NAIC Model Law #92: Stop Loss Insurance Model Act.

[29] ERISA §514(b)(2)(B) prevents states from deeming a plan declared to be self-funded plan to be a fully insured plan. The U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA) provides in Advisory Opinion 2008-07A that "a state law 'purporting to regulate insurance' generally cannot deem an employee benefit plan to be an insurance company (or in the business of insurance) for the purpose of regulating such a plan as an insurance company."

[30] Advisory Opinion 2008-07A (see above note) goes on to state that "An additional piece of analysis, however, is needed if the ERISA welfare plan is a MEWA as defined in section 3(40) of ERISA. Specifically, ERISA §514(b)(6)(A) creates a partial exception to the deemer clause [that is ERISA §514(b)(2)(B)] for employee welfare benefit plans that are also MEWAs. If the employee benefit plan MEWA is "fully insured," then, under §514(b)(6)(A)(i), any state law that regulates insurance may apply to the MEWA directly to the extent the law provides standards, or provisions to enforce those standards, requiring the maintenance of specified levels of reserves and contributions in order to be considered able to pay benefits. If the employee benefit plan MEWA is not "fully insured," then, under §514(b)(6)(A)(ii), the MEWA may be directly regulated under any law of any State which regulates insurance [if] the law is "not inconsistent with" the provisions of ERISA."

2.3 Multiple Employer Welfare Arrangements

A Multiple Employer Welfare Arrangements (MEWA) is a type of employee benefits arrangement where two or more unrelated employers join together to provide healthcare coverage and/or other fringe (welfare) benefits (e.g., dental, vision, disability, or life insurance) to their employees.[31] MEWAs are not new—they have been in operation for many years (U.S. Department of Labor 2022). While the employers need not be a part of the same corporate family, they do need some connection, although this connection is rather broadly defined. For example, the employers may be linked by a trade association or a professional group, or they may have an "association health plan (AHP)" structure. These might include (1) Professional Employer Organizations (PEOs), (2) TPAs, (3) Trusts marketed directly to unrelated employers, (4) Franchisor/franchisee arrangements, or (5) Church or rural cooperative plans that do not qualify for exemptions.[32] MEAWs often take the form of AHPs (see Section 2.3.2).

MEWAs are designed to increase access to benefits for small businesses or groups that might not otherwise be able to afford them. By pooling their contributions, small employers in a MEWA are positioned to offer health insurance and other fringe benefits at better quality and/or lower cost, like what might be offered by large-group employers. MEWAs tend to focus on healthcare benefits. From an insurance perspective, the pooled group, being larger, has less objective risk, which would manifest in lower premiums, all else equal. MEWA members may also benefit from administrative efficiencies such as shared plan documents and TPA scale economies.

MEWAs can be fully funded or self-funded. In the case of a fully funded MEWA, it purchases a large group policy from an insurance carrier. A self-funded MEWA pays claims directly from pooled employer contributions.

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[31] See *Employee Retirement Income Security Act (ERISA), §3(40), 29 U.S.C. §1002(40)*, which provides the legal definition of a MEWA and describes when a health arrangement covering multiple employers becomes a MEWA. The MEWA should not be confused with a Multiple Employer Plan, which is a shared retirement plan that is adopted by two or more unrelated employers, allowing them to benefit from the lower per-employee costs that come with larger scale. The main difference between a Multiple Employer Plan and an MEWA is that a Multiple Employer Plan is a retirement plan, while a MEWA provides pooled health care coverage and other fringe benefits (see Twin (2025). MEWAs are sometimes (but rarely) described as "Multiple Employer Trusts" (METs).

[32] A PEO is a company that partners with small and mid-sized employers to handle many of their HR, payroll, benefits, and compliance responsibilities. When a business joins a PEO, the two parties enter a co-employment relationship: the employer continues to direct day-to-day work, hiring, firing, schedules, and operations, while the PEO becomes the "employer of record" for certain administrative and tax purposes. See IRS, "Third Party Payer Arrangements – Professional Employer Organizations."

2.3.1 Regulation[33]

Historically, a sizeable number of MEWAs have been unable to pay claims because of insufficient funding and inadequate reserves. In some cases, they were operated by individuals who exhausted the MEWA's assets through excessive administrative fees and even embezzlement.[34] These incidents were antecedents to the rigorous dual oversight of MEAWs, which is intended to prevent fraud and insolvency, with states having broader authority over self-funded MEAWs than over traditional single-employer ERISA plans.[35]

Recognizing that it was both appropriate and necessary for states to be able to establish and enforce state insurance laws with respect to MEWAs, Congress amended ERISA in 1983 (P. L. 97-473), which provided an exception to ERISA's broad preemption provisions for the regulation of MEWAs under state insurance laws.[36]

Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. If the MEWA was not an ERISA-covered plan (as in most cases) most of ERISA's preemption provisions did not apply and states were free to regulate the entity in accordance with applicable state law.

Although the 1983 ERISA amendments were intended to remove federal preemption as an impediment to State regulation of MEWAs, MEWA marketers and others continue to create confusion as to the ability of states to regulate MEWAs. They claim ERISA coverage and protection from state regulation under ERISA's preemption provisions. To the extent such claims discourage or delay the application and enforcement of state insurance laws, the MEWA marketers benefit and those dependent on the MEWA for healthcare coverage bear the risk.

MEWAs are currently subject to a hybrid of federal (ERISA) and state regulation, created by ERISA §514(b)(6) to address past abuses like insolvencies and fraud. ERISA generally preempts state laws relating to employee benefit plans [ERISA §514(a)], but MEWAs have a specific exception allowing greater state oversight. The Department of

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[33] Much of the information in this section is available in U.S. Department of Labor (2022). See also ERISA §3(40) and NAIC, *State Licensing Handbook*, Chapter 25, "Multiple Employer Welfare Arrangements;" and the text for P.L. 97-473.

[34] The ACA granted the DOL authority to issue *ex parte* cease-and-desist orders for fraud, misrepresentation, or imminent danger to participants, and summary seizure orders for assets in hazardous financial condition (ERISA §521).

[35] Congress amended ERISA in 1983 (P. L. 97-473) to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under state insurance laws.

[36] P.L. 97-473 is known primarily for the *Indian Alcohol and Substance Abuse Prevention and Treatment Act*. Title II made technical and substantive amendments to ERISA.

Labor (DOL) (through the Employee Benefits Security Association [EBSA]) and states have concurrent jurisdiction, with states primarily handling solvency, licensing, reserves, and consumer protections, while the DOL largely handles ERISA fiduciary, reporting, and disclosure rules.

An arrangement qualifies as an ERISA plan [under ERISA §3(1)] only if established or maintained by an employer, employee organization, or both. Many MEWAs function as vehicles to fund or administer separate ERISA plans for individual participating employers rather than as a single ERISA plan. In these cases, each participating employer's coverage is typically treated as a separate ERISA plan. Further, the MEWA itself may not be ERISA-covered, meaning ERISA's broad preemption of state law does not fully apply to it.

Fully insured MEWAs are treated like any other employer offering fully insured small-group or large-group healthcare coverage. They are primarily regulated by the states but must also comply with certain federal regulations, in particular, ACA market reforms.

Self-funded MEWAs are subject to ACA "group health plan" mandates, such as no annual dollar limits on essential health benefits, no preexisting condition exclusions, and coverage of preventative services with no cost sharing.[37] However, self-funded MEWAs are not subject to ACA market reform rules that *apply only to insurers*, such as community rating, risk adjustment, guaranteed issue, and minimum medical loss ratios (MLRs).[38]

[37] Initially, these mandates also included the employee shared responsibility payment and minimum essential coverage. The ACA mandated that "applicable large employers" (ALEs) offered affordable health insurance that provided minimum essential coverage and minimum value to their employees. If an ALE did not comply, they faced potentially severe federal tax penalties. However, under the Tax Cuts and Jobs Act of 2017, the individual shared responsibility payment was reduced to $0, effective for months after December 31, 2018.

[38] Under a "community rating" system, health insurance premiums are based on the average cost of healthcare for a specific geographic area rather than individual characteristics. Insurers can charge more for older enrollees and, in some states, insurers can charge higher premiums for tobacco users. "Risk adjustment" prevents health insurance companies from avoiding the enrollment of individuals with higher health care costs, such as those with pre-existing conditions by redistributing funds from health plans with healthier enrollees to those with sicker enrollees. Guaranteed issue is a provision that requires health insurance companies to enroll any applicant who applies, without regard to their medical history or health status. The medical loss ratio is the percentage of insurance premium revenue that a health insurer spends on paying claims for medical care and activities that improve health care quality, as opposed to administrative costs, marketing, and profits. Under the ACA, insurers in the individual and small group markets are required to spend at least 80% of premium income on health care claims and quality improvement, while large group insurers must spend at least 85%. Insurers who fail to meet these minimums must pay rebates to policyholders.

Most self-funded MEWAs can avoid some state regulations as well when the state lacks approved authority. These include state-mandated mental health benefits that exceed federal requirements (such as those under the Mental Health Parity and Addiction Equity Act [MHPAEA]); state definitions of "small group"; rating restrictions (such as age bands); state-specific underwriting limits; state benefit design rules; and state network adequacy standards. In addition, by avoiding state solvency safeguards like reserve requirements, contribution and other requirements applicable to insurance companies, MEWAs are often able to market insurance coverage at rates substantially below those of state-regulated insurance companies, thus, in concept, making the MEWA an attractive alternative for those small businesses finding it difficult to obtain affordable health care coverage for their employees.

2.3.2 Association Health Plans

Association Health Plans (AHPs) are group health insurance arrangements that allow small employers to join together through a bona fide association to purchase coverage as a single large-group health plan under ERISA §3(5).[39] To qualify as a bona fide ERISA employer group, the participating employers must share a genuine commonality of interest, such as operating within the same industry or trade. The association must also be established for a primary purpose other than providing health insurance and must be controlled by its employer-members rather than by a commercial insurer.

AHPs inherently meet the MEWA criteria because they involve multiple unrelated employers (via the association) pooling for health benefits. ERISA and DOL guidance explicitly classify AHPs as a subset of MEWAs. Thus, every AHP is a MEWA, but not every MEWA is an AHP. For example, MEWAs can cover non-health benefits like dental or vision insurance, or they can be structured through professional employer organizations rather than associations. **Table 2** details some of the unique features of AHPs vis-à-vis MEWAs more generally.

A 2018 rule sought broader formation criteria for AHPs. The rule broadened eligibility by allowing associations based solely on geographic proximity and permitting self-employed individuals without common-law employees to participate. However, these provisions were vacated by the courts and were formally rescinded in 2024.[40] Current federal law is governed by the pre-2018 ERISA guidance described above. AHPs that

[39] For additional information on AHPs, see Claxton, Rae, and Winger (2025); Corlette (2019); (U.S. Department of Labor 2022); and Cheryl Hughes, "Final Association Health Plan Rule Offers New Options for Employers," Mercer, November 8, 2018.
[40] See U.S. Department of Labor, Employee Benefits Security Administration, "Fact Sheet: Department of Labor Rescinds Invalidated Rule on Association Health Plans," April 29, 2024.

meet these requirements are treated as large-group health plans under ERISA and are therefore not subject to ACA individual or small-group market rules, including requirements related to essential health benefits and community rating.

Table 2. Association Health Plans as MEWAs

Feature	Association Health Plans	Non-AHP MEWAs
Organizational Requirement	Must be sponsored by a *bona fide* association with a real purpose other than offering health insurance.	A bona fide association is not required; any group with multiple employers may establish a MEWA.
Commonality of Interest	Employers must share a common trade/industry or common geographic area.	No commonality requirement: employers may be unrelated.
Employer Control Standard	Employers must collectively control the association and the health plan.	No employer-control requirement.
Single-Employer Treatment	May qualify as a single-employer ERISA plan for large-group regulation.	In general, these arrangements do not meet the criteria for a single employer plan and therefore continue to be classified as multi-employer MEWAs.
ACA Market Classification	Created to enable access to rules for large groups, such as bypassing EHBs and using adjusted community rating.	Eligibility is generally determined by either small-group or individual ACA regulations, according to the employers involved.
Membership Restrictions	Membership is restricted to employers within the association's industry or region.	No required limits on employer or location.
Policy Intent	Developed to give small businesses an alternative similar to large-group ACA coverage.	There is no explicit policy objective; this term refers solely to a classification of multi-employer plans.

AHPs are primarily designed to offer small employers access to more affordable and flexible health coverage by: (1) pooling together to gain greater purchasing power and create a broader risk pool similar to that of large employers; (2) exercising greater discretion in benefit design, given their exemption from certain ACA small-group market requirements described above; and (3) improving administrative efficiency by enabling multiple employers to participate in a single, consolidated plan. However, critics caution that AHPs may contribute to adverse selection,

diminished benefit protections, and potential destabilization of the broader insurance market (American Academy of Actuaries 2017).

AHPs can be structured as fully-insured, self-funded, or level-funded arrangements. The choice of funding mechanism affects the scope of regulatory oversight. While fully insured AHPs are subject to state insurance laws, self-funded AHPs are governed primarily by ERISA but are typically classified as MEWAs, which allows states to regulate them in areas such as solvency and consumer protection. Level-funded AHPs, which combine fixed monthly payments with stop-loss protection, have emerged as a hybrid option that offers some predictability while retaining employer risk exposure. As with other self-funded AHPs, they fall primarily under ERISA but may also face limited state oversight, particularly with respect to the regulation of stop-loss insurance and certain minimum standards imposed by state insurance departments.

Despite policy interest, AHP uptake has been relatively limited in recent years. This is partly due to ongoing legal uncertainty, regulatory complexity, and inconsistent treatment across states. For example, some states have adopted a "look-through" approach where regulators "look through" the association and apply small-group or individual market rules based on the size and characteristics of each underlying employer or member rather than treating the association as a single large group, while others have adopted a more passive approach (Lucia et al., 2018).[41] As a result, the feasibility and attractiveness of AHPs can vary significantly depending on the regulatory environment.

2.4 Individual Coverage HRAs and Qualified Small Employer HRAs

Individual Coverage HRAs (ICHRAs) and Qualified Small Employer HRAs (QSEHRAs) represent emerging alternatives to traditional group health insurance, particularly among small and mid-sized employers seeking more flexibility in benefits design.[42] ICHRAs, which allow employers to reimburse employees for individual market insurance premiums and qualified medical expenses with tax-advantaged dollars. ICHRAs offer flexibility, predictable budgeting, and administrative simplicity. QSEHRAs offer similar benefits, but they are available only to small employers with fewer than 50 FTEs. Unlike ICHRAs, QSEHRAs have annual contribution caps set by

[41] California, Connecticut, Kansas, Maryland, New York, Pennsylvania have adopted a "look-through" approach" for fully insured AHPs. Connecticut, Maryland, New York, Pennsylvania have adopted a "look-through" approach" for self-funded AHPs.

[42] For additional information, see CMS, "Individual Coverage Health Reimbursement Arrangements: Policy and Application Overview," Fall 2020 and Healthcare.gov, "Qualified Small Employer HRAs (QSEHRAs)."

the IRS. For 2025, the QSEHRA total reimbursement maximum is $6,350 for single coverage and $12,800 for family coverage (Internal Revenue Service 2025).

ICHRAs and QSEHRAs offer several notable advantages for both employers and employees. These arrangements provide employers with greater flexibility and predictability in managing health benefit costs, as they allow for defined contributions rather than open-ended premium obligations. Employees, in turn, gain increased choice and autonomy in selecting individual market plans that best fit their needs, as opposed to being limited to a single group plan chosen by their employer. The administrative processes associated with ICHRAs and QSEHRAs can also be simpler for small businesses, reducing the burden of managing group coverage. In addition, by decoupling health benefits from traditional group insurance, these models can expand access to health coverage for employees of small and mid-sized firms that might otherwise be unable to offer comprehensive health benefits. Early evidence suggests that these arrangements may be particularly effective at reaching previously uninsured workers, thereby broadening the overall coverage landscape.

States are beginning to view these arrangements as a scalable strategy to support small businesses. For example, in 2023, Indiana established a dedicated employer tax credit for ICHRA and QSEHRA adoption, allocating up to $10 million in credits annually for small businesses. Similarly, Georgia, Ohio, and Texas have proposed legislation that would provide tiered or contribution-based incentives to encourage small employers to adopt these models (HRA Council 2024-2025).

While ICHRAs and QSEHRAs offer new flexibility for employers and employees, several critiques have emerged regarding their broader impact and effectiveness. A primary concern is that in some regions, particularly rural areas, employees may face limited plan choices or reduced access to high-quality coverage on the individual market. Affordability also remains a challenge, as employer contributions may not fully offset higher premiums or out-of-pocket costs for certain workers, especially those with greater health care needs. Additionally, these arrangements can shift greater financial risk and administrative responsibility onto individuals, who must navigate plan selection and coverage details themselves. There is also apprehension that employers might use ICHRAs or QSEHRAs to steer higher-risk employees into the individual market, potentially contributing to adverse selection and destabilizing risk pools. Finally, the variability in benefits and provider networks among individual market plans may lead to less comprehensive or predictable coverage compared to traditional group health insurance.

Importantly, ICHRAs and QSEHRAs are attracting younger employees. The risk pools for ACA marketplace plans are improving as a result, which could lead to more stable insurance premiums over time.

2.5 Health Care Sharing Ministries (HCSMs)

Health Care Sharing Ministries (HCSMs) are typically faith-based nonprofit organizations that facilitate the sharing of medical costs among members. However, these ministries generally are not considered to be insurance and are not regulated as insurance by state or federal authorities. As of 2018, thirty states have enacted laws that explicitly exempt health sharing ministries from their State Insurance Codes (Volk, Curran, and Giovannelli 2018).

Proponents of HCSMs point to several potential advantages. First, the monthly share amounts required by these ministries are often lower than traditional health insurance premiums, which can make them an attractive option for individuals and families seeking to minimize regular health care spending. In addition, many members are drawn to the sense of community and shared faith values that these organizations foster, as the model is often built around principles of mutual aid and collective responsibility. HCSMs also typically offer greater flexibility in provider choice because they generally do not restrict members to a specific network of doctors or hospitals. Finally, the administrative processes associated with these arrangements are often simpler and more personal compared to those of large insurance companies, which can be appealing to individuals who prefer less bureaucratic systems.

Despite these advantages, HCSMs also present several important limitations. First, these ministries often exclude coverage for pre-existing conditions and certain categories of care. There is also no legal guarantee that members' medical expenses will be paid. One common restriction involves maternity care: many ministries require a waiting period before members become eligible for reimbursement of maternity expenses. For example, among the ten largest health sharing ministries, at least eight impose such restrictions.[43] In addition, some ministries may require members to make an extra payment at the end of the year if regular monthly contributions have not been sufficient to cover all eligible expenses.

Some small employers have considered offering health sharing ministries as an option for employees who lack access to traditional health coverage. However, it is important to recognize the significant risks associated with these arrangements, especially for employees with substantial or ongoing medical needs. The absence of

[43] See Aria Bendix, "Faith-Based Cost-Sharing Seemed Like an Alternative to Health Insurance, Until the Childbirth Bills Arrived," NBC News, December 22, 2004.

guaranteed payments, exclusions for pre-existing conditions, and restrictions on certain types of care all pose considerable financial risks for members.

3. Trends in the Small Group Health Insurance Market

3.1 Trends in Arrangement Adoption

As small businesses have gained access to a broader set of insurance options, their adoption patterns have shifted significantly. Changes in policy, regulation, and employer preferences have all contributed to evolving market dynamics, with some coverage options experiencing rapid growth while others have stabilized or declined. This section reviews the latest data on adoption trends across key arrangements in the small group market, key factors driving these changes, and the implications for small businesses, their employees, and policymakers.

The landscape for AHPs shifted markedly after the 2018 rule expanded eligibility criteria, enabling sole proprietors and businesses located within the same state or metropolitan area to form AHPs. This regulatory change led to a temporary surge in AHP enrollment, particularly in states that adopted a more permissive regulatory stance. According to press announcements and news articles, over 30 new AHPs entered the market shortly after the rule's introduction; however, detailed information is available for 28 of these new plans (Coleman, n.d.). Among these, 43% permitted sole proprietors to participate, while 54% restricted membership to employers with two to fifty employees. Notably, 38% of fully insured plans and 75% of self-funded plans within this cohort allowed sole proprietors to participate. Most new AHPs were organized at the regional level, with 71% forming as associations through local Chambers of Commerce. These associations often have substantial projected eligible membership; for example, the Georgia Chamber of Commerce estimates that its statewide insurance pool could eventually encompass up to 800,000 eligible enrollees.

In addition to AHPs, enrollment in HCSMs has increased substantially over the past decade. Specifically, fewer than 200,000 individuals were enrolled in HCSMs before 2010, but estimates suggest that by 2023, membership has reached at least 1.7 million. (KFF, 2023; Volk et al. 2018). The most significant growth occurred in the years following the passage of the ACA, as some consumers sought alternatives to traditional insurance. More recently, the pace of enrollment growth has slowed, likely due to improvements in ACA marketplace subsidies and the elimination of the federal individual mandate penalty.

In parallel with these developments, adoption of ICHRAs and QSEHRAs has also grown rapidly. Recent data show that ICHRA adoption has increased by more than

1,000% between 2020 and 2025, and QSEHRA adoption has doubled over the same period.[44] "HRA Council members are reporting increases of 400-800% in employer requests for quotes for 2026 and 2027."[45] In addition, 17% of new ICHRA or QSEHRA adopters in 2025 previously offered traditional group insurance, while 83% had not offered any health benefits prior to adopting these arrangements (HRA Council, 2025). The growth in adoption is driven by two key factors. First, an expanding network of ICHRA and QSEHRA service providers has helped increase awareness and accelerate the implementation of these arrangements nationwide. Second, employers increasingly view these arrangements as a sustainable and customizable approach to providing health coverage and as a valuable tool for attracting and retaining talent. As the adoption of these arrangements continues to expand rapidly, the evolving state policy initiatives and critiques discussed above underscore the need for ongoing monitoring and careful policy attention.

At the same time, recent survey data offer insight into the dynamics of the traditional group insurance market. Among those employers who continue to offer traditional group plans, the types of plans selected have shifted markedly over the past several years. Specifically, the percentage of covered workers in firms with 3 to 199 employees enrolled in level-funded or self-insured plans (as opposed to fully-insured plans) has risen substantially from 19% in 2018 to 51% in 2025 (see Figure 9). [46] This shift reflects small employers' desire for greater cost control and flexibility.

3.2 Trends in Premium, Cost-Sharing, and Plan Design

Over the past two decades, average annual health insurance premiums for both single and family coverage have risen steadily among employers of all sizes. As illustrated in **Figure 10**, the average annual premium for family coverage increased from $5,809 in 1999 to $26,993 in 2025, representing a compound annual growth rate (CAGR) of 6.1%. For single coverage, premiums rose from $2,195 in 1999 to $9,325 in 2025 over the same period, representing a similar CAGR of 5.7% (KFF, 2025). This persistent upward trend highlights the ongoing affordability challenges faced by small employers and their employees.

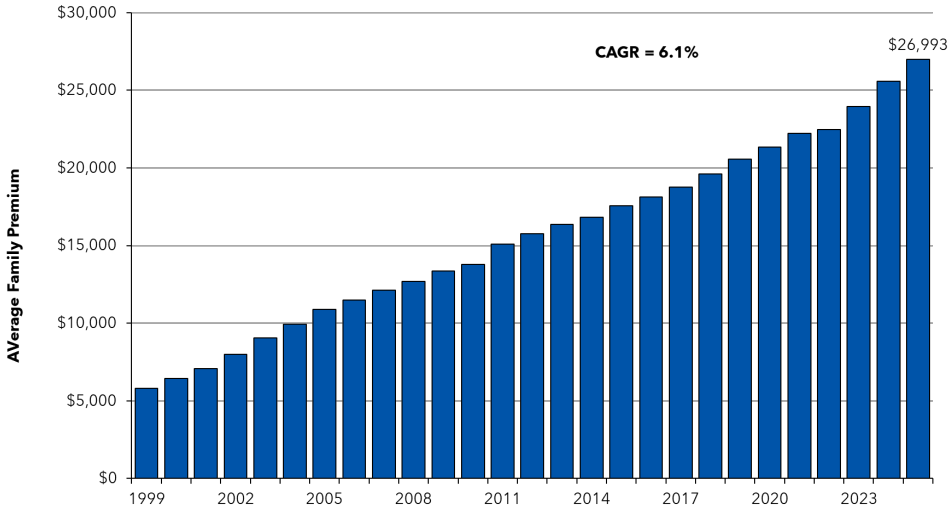
Comparing small firms to large firms, in 2025 the average premium for single coverage among small employers is $9,361 per year, closely mirroring the large firm

[44] Jakob Emerson, "ICHRA Growth Up 1,000% Since 2020: 8 Notes," *Becker's Payer Issues*, June 17, 2025.
[45] Ibid.
[46] See also KFF, 2025. KFF defines "small firms" as those with 10–199 workers, while the ACA defines small businesses as firms with fewer than 50 employees.

average of $9,211. For family coverage, the average small group premium is $26,054, slightly below the large firm average of $27,280 (KFF, 2025).

Premium variation is also shaped by plan type. The average annual premiums for covered workers in high-deductible health plans with a savings option (HDHP/SOs) are lower than those in preferred provider organization (PPO) plans across all employers by about 12% for single coverage and 10% for family coverage. Despite these differences, PPOs remain the most common plan type in 2025: 46% of covered workers are enrolled in a PPO, while 33% are enrolled in an HDHP/SO (KFF, 2025).

Figure 10. Trend in Annual Family Health Insurance Premiums



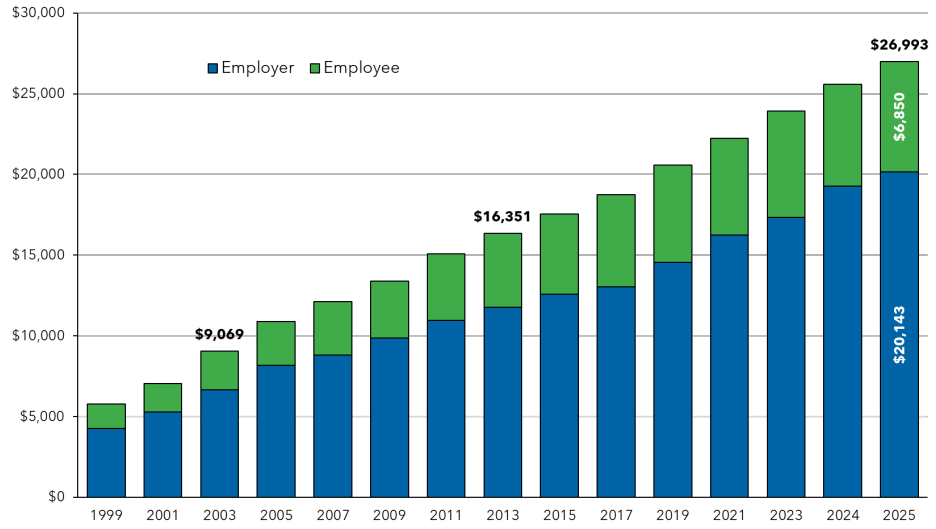
Source: KFF Employer Benefit Survey, various years.
Note: "CAGR" indicates compound annual growth rate.

Between 2015 and 2025, both employer and worker contributions toward family coverage premiums have increased steadily. As shown in **Figure 11**, the average total premium for family coverage rose by 53%, from $17,680 in 2015 to $26,993 in 2025. Over this period, workers' average annual premium contribution increased by 37%, from $4,993 to $6,850, while employer contributions grew by 59%, from $12,687 to $20,143. This trend indicates that employers have continued to bear a larger share of rising health insurance costs.

In 2025, covered workers contribute an average of 16% of the premium for single coverage and 26% for family coverage. Notably, the contribution rate for single coverage is the same for employees in both small and large firms, but there is a substantial difference in family coverage: workers in small firms pay, on average, 36% of the total premium, compared to 23% among those in large firms. The distribution of premium contributions for family coverage further highlights this disparity. As shown in **Figure 12**, in large firms, nearly two-thirds of workers pay no more than 25%

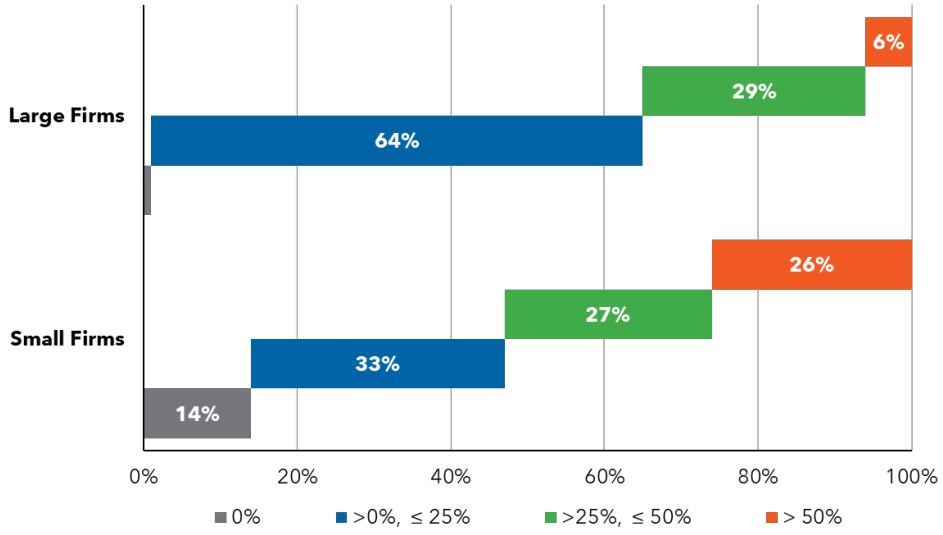
of the premium, and only 6% pay more than half. In contrast, just one-third of workers in small firms pay no more than 25% of the premium, while over a quarter pay more than half the total premium.

Figure 11. Employer-Provided Group Health insurance Premiums



Source: CIPR analysis of data from the KFF 2025 Employer Benefits Survey

Figure 12. Employer and Employee Contributions to Health Insurance Premiums (Family Coverage)



Data Source: KFF 2024 Employer Benefits Survey

Deductible levels have also increased substantially over time. Specifically, the average deductible for single coverage has risen by 17% over the past five years and by 43% over the past decade. In 2025, covered workers in small firms face an average deductible of $2,631 for single coverage, compared to $1,670 among those in larger

firms. The rise in deductibles is also reflected in the growing share of workers enrolled in a plan with a general annual deductible of $2,000 or more. Among small firms, this share increased from 42% in 2020 to 53% in 2025. In large firms, the share rose from 20% in 2020 to 28% in 2025. These trends suggest that the similarity in average premiums for single coverage between small and large firms noted earlier is partly attributable to less generous benefit designs in the small group market. While small employers typically have less bargaining power and smaller risk pools, which would ordinarily result in higher premiums, the greater prevalence of high deductibles and leaner plan designs among small firms helps keep their premiums at levels comparable to those of large employers.

4. Key Challenges in the Small Group Health Insurance Market

Despite a growing range of coverage arrangements and ongoing efforts to enhance plan flexibility, significant structural and financial challenges persist in the small group health insurance market. For many small businesses, rising costs, administrative complexity, and uneven access to affordable, comprehensive coverage remain major obstacles. These problems are compounded by persistent disparities in bargaining power where larger, self-funded employers can negotiate better rates and options than smaller, fully insured firms, as well as increasing risk segmentation across market segments and ongoing concerns about benefit adequacy and the consumer experience. As a result, small employers often struggle to offer and sustain health benefits that meet the needs of their workforce, with important implications for market stability, employee well-being, and broader policy goals.

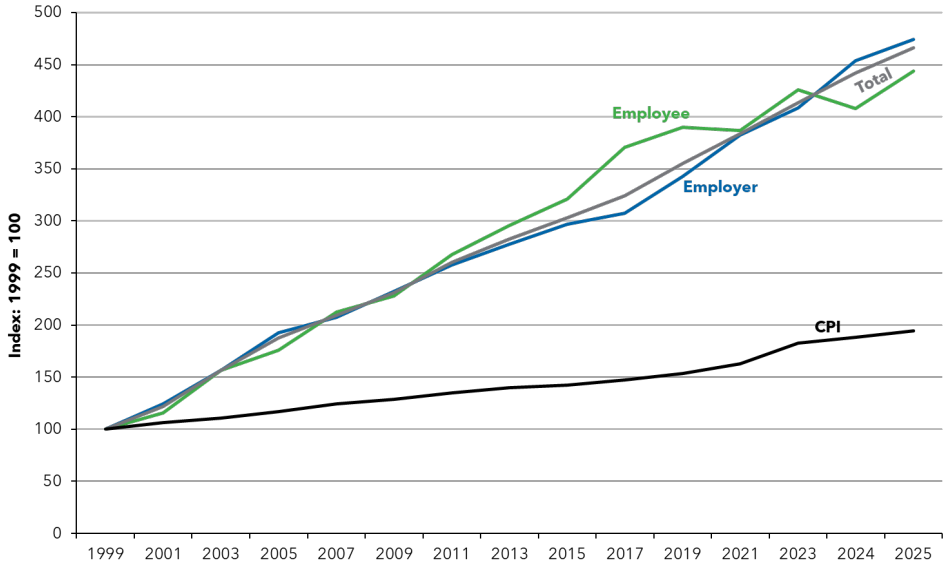
4.1 Affordability and the Cost Burden

Cost is consistently ranked as the top concern for small businesses considering or offering health insurance. Over the last 10 years (2015-2025), the cost of health insurance premiums has increased 56.4 percent, compared to a rise in general prices (consumer price index, or inflation) of 36.9% (**Chart 13**). Since 1999, premiums have increased 342%, compared with 95% for CPI. Employer and Employee premium portions have grown at approximately the same rate.

According to the National Federation of Independent Business (NFIB) Small Business Problems and Priorities Survey, the cost of health insurance ranks as the most severe challenge among 75 identified business issues (NFIB, 2024). Small employers face persistent financial pressure as premiums and employee payroll deduction amounts rise. Unlike larger firms, small businesses have less flexibility to absorb cost increases or to shift those increases onto employees without risking employee retention. For small employers, the share of compensation devoted to insurance benefits remains

markedly lower than among large employers, reflecting these limitations. Specifically, according to the BLS, in June 2025 private-industry establishments with 1–49 workers spent about 5.7% of total compensation on insurance benefits, compared with 7.3% in establishments with 50-99 workers and 8.6% in establishments with 100 or more workers (BLS, 2025).

Chart 13. Rise in Health Insurance Premiums Relative to Consumer Prices



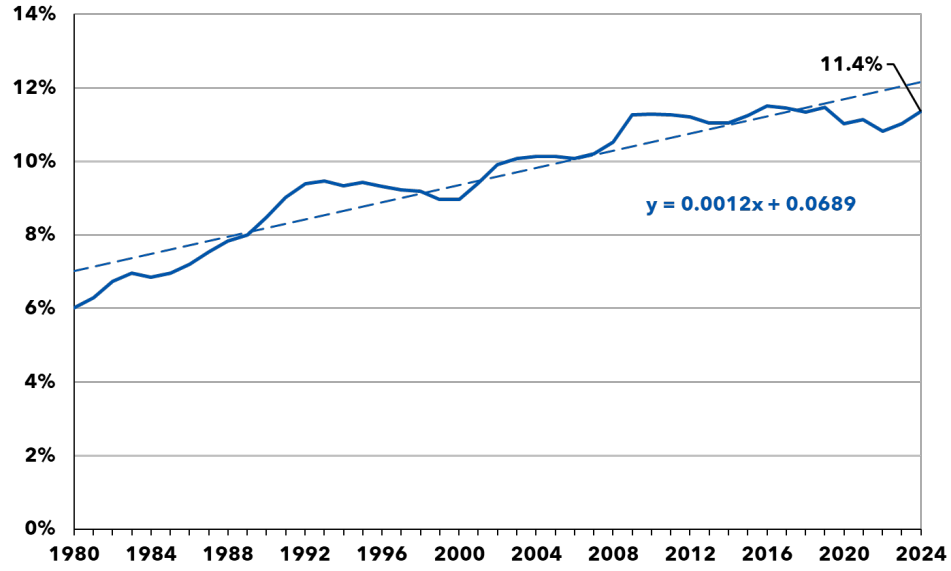
Source: CIPR/NAIC

The rise in premiums is largely a function of increased costs for medical care. Healthcare spending in the United States has increased from about 6% in 1980 to 11.4% in 2024 (**Figure 14**). Thus, healthcare has become a larger and larger share of the value of annual total output in the United States, or gross domestic product (GDP). The increase is 0.12 *percentage points* per year, as shown by the regression line.

4.2 Market Fragmentation and Risk Segmentation

Recent trends in the small group health insurance market point to increasing fragmentation and risk segmentation, particularly as more small employers consider self-funding and level-funding options. These arrangements are especially attractive to low-risk groups because they allow employers to avoid certain ACA and state-mandated small group insurance requirements and to risk-rate their policies. As a result, when healthier, younger small groups opt for self-funding or level-funding, the remaining fully insured small employer group market is left with a higher concentration of older, sicker, and higher-risk employees.

Figure 14. Healthcare Expenditures as a Share of GDP



Source: CIPR

Over time, this adverse selection may threaten the stability of the fully insured small group market, leading to higher premiums and reduced plan choices for those who remain. Market fragmentation also may make it more difficult for policymakers to ensure equitable access to affordable, comprehensive coverage and may increase the administrative and compliance burden for small employers navigating a complex landscape of plan types, funding mechanisms, and regulations.

4.3 Consumer Experience and Adequacy of Coverage

While coverage options have expanded, many consumers continue to face significant barriers in their health insurance experience. According to the 2023 KFF Survey of Consumer Experiences with Health Insurance, approximately six in ten insured adults reported experiencing at least one problem with their health insurance in the previous year. Among those with employer-sponsored coverage, the most frequently cited issues included insurance paying less than expected for services (35%) and difficulty finding available appointments with in-network providers (28%) (KFF, 2023). Although the survey did not provide a breakdown by employer size, the data highlight that substantial challenges persist across all forms of coverage.

Employees of small firms may be particularly vulnerable to coverage inadequacy, as small employers are less able to invest in robust insurance benefits due to budget constraints, as discussed in Section 4.1. As a result, workers in small businesses are more likely to encounter higher deductibles, narrower networks, and other forms of reduced benefit generosity. These factors can undermine the value of coverage,

increase financial stress for employees, and reduce satisfaction with employer-sponsored insurance.

4.4 Recent Policy Changes: Enhanced Advanced Premium Tax Credit (APTC) and Short-term Limited-duration Insurance (STLDI)

Recent federal policy changes are poised to significantly affect the affordability and availability of individual market coverage, with potential spillover effects for the small group market through shifts in coverage patterns, risk segmentation, and employer decision-making.

One of the most significant upcoming changes is the scheduled expiration of the enhanced APTC. The American Rescue Plan Act of 2021, later extended by the Inflation Reduction Act, temporarily increased the generosity of these subsidies through 2025, making individual market coverage substantially more affordable for millions of Americans, including many who might otherwise rely on small group plans. However, with these subsidies set to expire at the end of 2025 and Congress having not acted to extend them as of the start of the 2026 open enrollment period, premiums for many Marketplace enrollees will increase substantially in 2026. This premium spike is expected to reduce the affordability and attractiveness of individual coverage, prompting some employees to reconsider their participation in the Marketplace and potentially shift back toward group or alternative coverage arrangements, with ramifications for risk pools and overall market stability.

There is also significant uncertainty around the regulation of STLDI plans. In 2024, new federal rules were issued to sharply restrict the duration of these plans, aiming to limit their use as long-term substitutes for comprehensive coverage. However, as of August 2025, enforcement of these limits has been paused amid ongoing litigation and an executive order (Executive Order 14219) directing federal agencies to review regulations that may impose undue burdens on small businesses or private parties (White House, 2025). As a result, STLDI plans may continue to be available in some states as an alternative for healthy individuals seeking lower premiums. While STLDI may offer an immediate, lower-cost option, these plans lack ACA consumer protections, including guaranteed issue, coverage of pre-existing conditions, and essential health benefits, and their continued availability could further fragment risk pools in both the individual and small group markets.

5. Conclusion and Policy Implications

The small group health insurance market has undergone notable change and innovation over the past decade, with new arrangements expanding the choices available to small employers. These developments have enabled some employers to

better manage costs, tailor benefits to their workforce, and respond flexibly to a changing policy environment. In addition, state-level policy innovations such as targeted tax credits and defined-contribution incentives have helped some small businesses offer or sustain health coverage.

Despite these positive developments, significant challenges persist. Rising premiums, cost-sharing, and administrative complexity continue to limit the ability of many small businesses to offer robust, affordable coverage. Coverage adequacy and consumer experience remain pressing issues, with many employees, especially those in small firms, facing high deductibles, narrow provider networks, and increased financial risk from medical expenses. In addition, ongoing market segmentation and risk selection are raising broader concerns about the stability and equity of the small group market as a whole.

Looking ahead, policymakers and stakeholders will likely focus on several priorities that will shape the stability of the small group market. First, monitoring and responding to major policy shifts such as the scheduled expiration of enhanced APTC subsidies and ongoing uncertainty around STLDI regulations will be essential, as these changes could significantly alter coverage patterns and market dynamics in both the individual and small group markets. Timely action and data-driven oversight can help prevent coverage losses and support overall market stability.

Second, promoting risk-pool stability remains critical, particularly as employers experiment with level-funded and other alternative financing arrangements. Policy interventions that reduce adverse selection, including the use of reinsurance programs, clearer regulatory guidance on level-funding arrangements, or stronger market oversight, can help preserve a balanced mix of risks in the market. Reinforcing this balance is essential for keeping premiums predictable, preventing insurer withdrawal, and maintaining a viable market for all groups.

Third, advancing benefit adequacy and consumer protections should remain a central policy goal to ensure that all workers, regardless of employer size or market segment, have access to coverage that is comprehensive and shields them from undue financial risk. Finally, strengthening support for small employers through improved transparency, clearer disclosures on product features, pricing structures, and broker incentives across all small-group offerings, and more accessible decision-support tools can help businesses navigate an increasingly complex market environment. Streamlined regulatory requirements and targeted technical assistance can further enable employers to choose and sustain appropriate coverage options.

The fundamental challenges of affordability, equity, and adequacy in the small group health insurance market demand sustained attention from policymakers, industry

stakeholders, and researchers alike. Ensuring a stable and accessible small group market is not only critical for the viability of small businesses and the well-being of their employees, but also for supporting a healthy national workforce and preserving the integrity of the broader health insurance system. Continued vigilance, data-driven policy action, and ongoing collaboration will be essential to meet the needs of small employers and their employees in an evolving and increasingly complex market.

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