PARAGON HEALTH INSTITUTE

Expert Witness Testimony to the

Senate Committee on Health, Education, Labor and Pensions

"The Market Needs and Justification of Association Health Plans"

July 17, 2025

Chairman Cassidy, Ranking Member Sanders, and members of the Committee, this testimony is intended to illuminate the small business needs for Association Health Plans (AHPs) and the ways by which AHPs can satisfy those needs. My name is Kev Coleman and I am a Research Fellow at Paragon Health Institute, an independent, non-partisan policy research organization dedicated to reforming government and empowering patients. Prior to Paragon, I worked largely in technology startups including co-founding Association Health Plans, Inc. My testimony today represents my views alone.

The National Federation of Independent Business (NFIB) has found affordability to be a central obstacle for small firms wishing to offer health coverage to their employees. The 2024 edition of their quadrennial survey "Small Business Problems & Priorities" reported that health insurance cost remains "the number one small business problem, a position it has held since 1986."[1] This same study revealed that the cost of health insurance was the top reason given for not offering coverage to employees. Expanded association health plans are an essential tool in addressing the problem of health insurance affordability for small businesses and permitting more of these employers to offer health insurance to their workers including those who are self-employed or earning a living in the gig economy.

Regarding the affordability problem, the past decades have brought increased insurance expense for small business and declining coverage availability for its workers. Almost half of employers with fewer than 50 workers offered

[1] Survey results based on 2,873 business owners with membership in the NFIB. Holly Wade and Madeleine Oldstone, "Small Business Problems & Priorities," National Federal of Independent Business, 2024, https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf

health coverage in the year 2000 but by 2023, that percentage had fallen to 30.1 percent.[2] Within this period, there was also a significant decline in the use of small group health insurance. For example, data from the National Association of Insurance Commissioners (NAIC) shows there were 13,685,860 covered lives[3] (with comprehensive medical insurance) in the small employer health insurance market in 2014, the first year of small group coverage under the Affordable Care Act. Covered lives in this market dropped to 9,218,480 by 2023, decline of nearly a third within a decade.[4] The federal government's Medical Expenditure Panel Survey (MEPS) observed during this same period that the average cost of a single employee's health coverage in the private sector among small employers went from $5,886 annually to $7,974 annually[5], a 35 percent increase. The average annual premium for family coverage was $15,575 in 2014. By 2022, it averaged $21,351, a 37 percent increase.[6] Ultimately the entire premium expense of individual and family coverage is borne by employees, including the employer share, as the employer share represents foregone wage compensation.[7]

The premium increases for individual and family coverage were accompanied by an escalation in employee insurance contributions. Employees enrolled in single coverage at a small business had their insurance contribution increase 68 percent, from an average of $1,035 in 2014 to $1,734 in 2023.[8] The increase for family coverage was

[2] AHRQ, "MEPS IC," "Percent of private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[3] National Association of Insurance Commissioners, "2014 Accident and Health Policy Experience Report," 2015.
[4] Covered lives apply to employees with comprehensive medical insurance within U.S. small employers. "Small group health plan means a health plan offered in the small group market as such term is defined in state law in accordance with the federal Public Health Service Act (PHSA). The Proctecting [sic] Affordable Coverage for Employees Act as Public Law 114-60 (PACE Act) amended section 1304(b) of the ACA and section 2791(e) of PHSA on October 7, 2015, to revise the definition of small employer for the purposes of the market reforms under title 1 of the Affordable Care Act and title XXVII of the Public Health Service Act. The PACE Act generally defines a small employer as an employer who employed an average of 1-50 employees on business days during the preceding calendar year, but provides States the option of extending the definition of small employer to include employers with up to 100 employees." National Association of Insurance Commissioners, "2023 Supplemental Health Care Exhibit Report," 2024, https://content.naic.org/sites/default/files/hcs-zb-22.pdf
[5] AHRQ, "MEPS IC," "Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees. See also https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2023/ic23_ia_g.pdf
[6] AHRQ, "MEPS IC," "Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees. See also https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2023/ic23_ia_g.pdf
[7] "New research shows that increasing health insurance costs are eating up a growing proportion of worker's compensation, and have been a major factor in both flattening wages and increasing income inequality over the past 30 years." Jen A. Miller, "Cost of Employer-Sponsored Health Insurance is Flattening Worker Wages, Contributing to Income Inequality," Tufts University, January 16, 2024, https://now.tufts.edu/2024/01/16/cost-employer-sponsored-health-insurance-flattening-worker-wages-contributing-income
[8] AHRQ, "MEPS IC," "Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.

even more severe at 70 percent. In 2014 an employee with family insurance coverage paid an average of $4,426 annually. By 2023, that average contribution swelled to $7,529.[9] On top of employee insurance costs rising, there was also an increase in the amount of money paid out-of-pocket for medical care before insurance payments began. For individuals, deductibles rose from $1,777 for individuals in 2014 to $2,493 in 2023[10] while families saw average deductibles increase from $3,810 to $5,074.[11]

The affordability problem for small companies is exacerbated by the fact that many of these companies pay more than big businesses for the same health benefits. This is as true for a small business with multiple workers as it is for a sole proprietor performing gig work. Among the factors contributing to this disparity is the unequal legal treatment of individual and small group health plans versus large group health plans. For example, fully-insured health plans in the large group market are required by law to devote fewer premium dollars toward profit, administrative, and other overhead costs. This requirement, known as the Medical Loss Ratio (MLR), reduces large group premium dollars spent on profit and overhead by 25 percent, which effectively lowers the overall cost of the large group plan by 5 percent for the same benefits as compared to a small group or individual health plan.

Within the context of these financial and legal conditions, association health plans offer small businesses, including the self-employed, a means by which health insurance is made more affordable. Technically, an association health plan is not a type of insurance but rather a legal instrument whereby a group of businesses can band together and cooperatively sponsor a single health plan limited to the group's workers. If there are at least 51 employees across the employer group, the AHP can legally offer the same large group health coverage used by big businesses and the savings advantages it provides. There are many antecedents for such a cooperative arrangement, such as association retirement plans, professional employer organizations, credit unions, and group captives. In each of

[9] AHRQ, "MEPS IC," "Average total employee contribution (in dollars) per enrolled employee for family coverage at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[10] AHRQ, "MEPS IC," "Average individual deductible (in dollars) per employee enrolled with single coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2023," Firm size: fewer than 50 employees.
[11] AHRQ, "MEPS IC," "Average family deductible (in dollars) per employee enrolled with family coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2023," Firm size: fewer than 50 employees.

these examples, organizations employ a similar strategy where demand for products/services is pooled among multiple businesses who voluntarily work together to secure lower prices from suppliers.

Regarding the prospect of AHPs extending membership employers who are sole proprietors, gig workers, or otherwise self-employed, there is also precedent modeled by the Internal Revenue Service. Its Simplified Employee Pension plan (SEP) "allows employers to contribute to traditional IRAs (SEP-IRAs) set up for employees" and acknowledges that eligible employers include "a business of any size, even self-employed."[12] Likewise, under the Affordable Care Act, a 1332 waiver was approved so the state of Maine could combine its individual and small group markets together[13] in an effort driven in part by the desire to hold down the health insurance costs for small businesses.[14] AHP extension to gig workers and the self-employed, given this context, is hardly controversial.

Returning to the theme of health insurance affordability for small businesses, one of the ways a large group health plan achieves insurance cost savings is scale. Large group plans covering thousands of employees are in a better position to negotiate with insurers, because a large plan offers an insurer a bigger risk pool over which health claims may be spread and moderated. In some cases, these large plans can also negotiate lower rates with health care providers (because large plans offer providers a large volume of patients to utilize their services). Additionally, health insurance loads (i.e., the premium portion that exceeds expected medical expenditures paid by the insurer) are lower for large groups.[15]

Large group plans also avoid the cost of Healthcare.gov's "user fee" (2.75% of premiums) factored into on-exchange "individual" health coverage purchased by self-employed businesses. Likewise, fees for small group plans on a

[12] https://www.irs.gov/retirement-plans/plan-sponsor/simplified-employee-pension-plan-sep

[13] Christian Wade, "Feds approve Maine's plans to merge insurance coverage," The Center Square, July 18, 2022, https://www.thecentersquare.com/maine/article_43ce3f58-06d9-11ed-b35e-931b522c8774.html

[14] State of Maine, "Federal Government Approves Maine's Plan to Improve Health Insurance for Small Businesses," July 15, 2022, https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15#:~:text=Under%20the%20now%2Dapproved%20waiver,of%20pandemic%2Drelated%20financial%20assistance.

[15] See P. Karaca-Mandic, J. Abraham, and C. E. Phelps, "How Do Health Insurance Loading Fees Vary by Group Size? Implications for Healthcare Reform," International Journal of Health Care Finance and Economics 11 (2011): 181–207; and M. V. Pauly, Health Reform without Side Effects: Making Markets Work for Individual Health Insurance (Stanford, CA: Hoover Institution Press, 2010).

state-based exchange may also be avoided. For example, in the case of a state-based exchange like Covered California, there is a charge of 5.2% of premiums for small group plans. Alongside the savings from such fee avoidance, the collective savings through an association health plan can be further increased if the plan chooses to separate supplemental benefits (e.g. dental and vision care) into separate plans that can be voluntarily purchased alongside the association's primary medical coverage. In this model, employees without need for dental and vision benefits do not pay for them while those who do still enjoy the savings of group rates.

Through an association health plan, otherwise known as an AHP, small businesses can band together and access the large group health insurance market that already covers over 80 million workers and dependents in big businesses. In the brief 2018 period when AHP reforms expanded small employers' ability to access the large group market, new AHPs provided both broad health benefits and double-digit savings. In my own research on nearly three dozen of these plans, the highest reported savings in a fully-insured AHP was 23 percent averaged across its members, and 29 percent at a self-insured AHP.[16] Separate research from the Coalition to Protect and Promote Association Health Plans found a Tennessee REALTORS AHP that provided savings of 25 to 50 percent.

The 1974 Employee Retirement Income Security Act (ERISA) codified AHPs as a subtype of Multiple Employer Welfare Arrangement (MEWA).[17] In the decades since ERISA's passage, the regulation of AHPs has evolved significantly to protect consumers on the federal level as well as the state level. Most importantly, Congress amended ERISA's preemption provision in 1983 giving states the authority to regulate self-insured MEWAs operating within their borders. States, for their part, have enacted numerous laws and regulations to improve AHP governance and oversight in the decades since this amendment.

[16] Kev Coleman, "First Phase of New Association Health Plans Reveal Promising Trends," AssociationHelthPlans.com, January 30, 2019, https://www.associationhealthplans.com/reports/new-ahp-study/

[17] According to data from the Department of Labor, there were at least 82.8 million people covered by large group health plans in 2021. Since this data only included health plans with at least 100 participants, it omits millions of covered lives in plans that are large group by virtue of meeting most States minimum large group plan size of 51 employees. Daniel S. Levy and Yekun Zhou, "Self-Insured Health Benefit Plans 2024 Based on Filings through 2021," Advanced Analytical Consulting Group, Inc., September 30, 2023, https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2024-appendix-b.pdf

Alongside these state regulatory efforts, other federal laws passed in the same period, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), introduced additional obligations on AHPs. Under HIPAA, an employee seeking coverage from his or her employer's large group AHP may not be denied eligibility or continued eligibility based on health factors. Specifically, an AHP is prohibited from denying coverage based on:

- Health status (e.g., obesity, a physical disability, etc.)
- Pre-existing medical conditions (e.g., diabetes, high blood pressure, etc.)
- Pre-existing mental illnesses (e.g., depression, bipolar disorder, etc.)
- Medical claims history (e.g., expensive health care bills resulting from an accident)
- Medical history
- Genetic information
- Disability

The Affordable Care Act (ACA) further requires group health plans – including AHPs offering major medical coverage[18] – to comply with the law's group health plan requirements. These requirements include no cost-sharing for certain preventive services and no annual and lifetime limits imposed on certain benefits covered by the AHP.[19]

[18] ERISA section 733(a)(1) and PHSA section 2791(a)(1) provide that a "group health plan" is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents…directly, or through insurance, reimbursement, or otherwise.

[19] As discussed later in this preamble, ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA, requiring an AHP to, among other things, Eliminate all pre-existing condition exclusions for all plan participants [PHSA section 2704]; Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan [PHSA section 2711]; Provide coverage for certain preventive health services with no cost-sharing [PHSA section 2713]; Cover "adult children" up to age 26 [PHSA section 2714]; Stop rescinding coverage absent fraud or misrepresentation [PHSA section 2712]; Include new internal and external appeals processes (and provide notice) [PHSA section 2719]; Allow participants a choice of primary care physician/pediatrician/OB/GYN [PHSA section 2719]; Provide direct access to emergency services [PHSA section 2719A]; Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information [PHSA section 2705]; Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014 [PHSA section 2707(b)]; Eliminate waiting periods that exceed 90 days [PHSA section 2708]; Provide participants with a summary of benefits and coverage [PHSA section 2715].

Opponents of AHPs have sought to prevent access to large group coverage by small businesses. However, these foes of AHPs are oddly silent regarding why large group coverage is acceptable for big businesses, universities, and nonprofits, but not traditional small businesses and the self employed. This double standard is all the more problematic given the insurance market conditions small businesses face.

Thank you for considering the information contained in this testimony. Please do not hesitate to contact me with any questions regarding its content or if you would like to schedule a meeting to discuss matters related to AHPs.