WHERE YOUR PREMIUM DOLLAR GOES

The Fully Insured Tax

What every employer paying $500,000+
in health premiums needs to know

HUB

Risk & Insurance | Employee Benefits | Retirement & Private Wealth

Table of Contents

Executive Summary 3

The Problem You Feel but Cannot See 4

The Anatomy of a Fully Insured Premium 4

The Complete Picture: Where Your $5.25 Million Goes 7

Why Your Premium Keeps Rising Even When Your Employees Stay Healthy 8

What Would a Different Funding Structure Cost You? 11

How to Know If You're Ready 14

Two Trajectories: What Five Years of the Same Structure Costs and What Five Years of a Different One Won't 16

You Have the Data. Here Is What to Do With It 19

Next Steps 20

Executive Summary

For every dollar you pay in fully insured premiums, only 80 to 86 cents reaches your employees' healthcare. The rest goes to carrier administration, profit margins, state premium taxes and risk loads, costs that have nothing to do with how sick or healthy your population actually is.

For a 300-employee company paying $5.25 million annually, that math produces between $735,000 and $1,050,000 in non-claims costs every year. Over five years, $3.7 million to $5.25 million. None of it touches a single claim.

The structural problem runs deeper than the dollar figure. The fully insured risk pool is deteriorating. As healthier groups move to self-funded arrangements, the groups that remain subsidize a more expensive pool. Carriers face no regulatory incentive to arrest that trend. The Affordable Care Act's (ACA's) Medical Loss Ratio rules reward premium growth, not cost efficiency.

Level-funded and self-funded arrangements significantly reduce or eliminate state premium taxes, reduce carrier overhead and return claims data to the employer. Industry data shows employers making this transition typically reduce total healthcare costs 5% to 8% by eliminating state premium taxes, reducing carrier overhead and removing embedded profit margins. The structural advantages extend further: claims transparency and plan flexibility that fully insured arrangements cannot provide.

For a $5.25 million premium, that is $262,500 to $420,000 annually, not from cutting benefits or shifting costs to employees, but from changing the structure.

If your last two renewals came in above 8% and you have not seen a real funding structure analysis, this document will show you what your premium actually buys and what a different structure would cost for your specific group. The planning window for influencing your next renewal is open now. It will not stay open indefinitely.

Jump to Your Section

Premium Dollar Breakdown

Hidden Costs of Staying Fully Insured

Alternative Funding Options

Self-Assessment Questions

Total Cost of Inaction

Next Steps

The Problem You Feel but Cannot See

You know the pattern. Every renewal season, your health insurance premiums increase: 7%, 9%, 12% or more. Your broker presents a new rate. Maybe they shop a few carriers. Maybe you negotiate it down a point or two. But ultimately, the number keeps climbing.

Most employers accept this as inevitable. Healthcare costs are rising. An aging population. New treatments. Prescription drug prices. Higher costs for providers and facilities. These are real factors, and they matter.

Most discover those factors too late, after the renewal is signed, when the window to evaluate alternatives has already closed for another year. If you have 100 or more enrolled employees, that window is open right now.

But here's the question almost no one asks: Do you know where every dollar of that premium is actually going?

Not in broad categories. Exactly where: How much reaches your employees' care, and how much goes to carrier overhead, profit margins and taxes you could legally eliminate?

Most CFOs can tell you their company's gross margin down to the basis point. They know their cost of goods sold. They understand their overhead structure. But when it comes to their second or third largest expense after payroll, that same level of visibility disappears. They pay a premium. Their employees get care. And what happens in between is a mystery.

This white paper will show you exactly where that money goes. The data comes from the National Association of Insurance Commissioners (NAIC), the Kaiser Family Foundation (KFF), and publicly available regulatory filings. Every number is cited and verifiable. What you discover may change how you think about your health benefits strategy.

A 9% renewal increases more than claims costs

Every component of the non-claims load scales with premium. When your premium increases 9%, the carrier's administration fee, profit margin, risk load and state premium tax all increase proportionally. You are paying a higher dollar amount on every structural cost line, not just on claims.

The Anatomy of a Fully Insured Premium

Let's start with a typical fully insured employer with 300 employees and $5.25 million in annual premiums. That's roughly $17,500 per employee per year, which aligns with national averages for employer-sponsored coverage.

Where does that $5.25 million go?

Medical claims: 80% to 86%

This is what you think you're paying for: Doctor visits. Hospital stays. Prescriptions. Lab work. The actual healthcare your employees receive.

The Affordable Care Act established minimum thresholds called Medical Loss Ratios (MLR). For large group plans (generally 50+ employees), insurers must spend at least 85% of premiums on medical claims and quality improvement activities. For small group plans, the minimum is 80%.[1] If insurers fail to meet these thresholds, they must issue rebates.

[1] Kaiser Family Foundation, "Explaining Health Care Reform: Medical Loss Ratio (MLR)," accessed June 15, 2026.

In practice, insurers tend to run slightly above these legal minimums. According to KFF's analysis of NAIC financial data, the medical loss ratio for the fully insured group market was approximately 86% in 2023.[2] That means 86 cents of every premium dollar went to medical claims. The remaining 14 cents went to everything else.

For our 300-employee company paying $5.25 million annually, that's $4.5 million going to medical care. The remaining $735,000 is split among several other categories.

Carrier administrative costs: 8% to 12%

Administrative costs include everything it takes to run a health insurance company: claims processing, network management, customer service, enrollment systems, IT infrastructure, compliance, actuarial services, marketing, sales and general overhead.

The NAIC reports the health insurance industry's aggregate expense ratio was approximately 11.2% for 2024.[3] That percentage has been relatively stable, ranging between 11% and 12% in recent years.

For our 300-employee example group, we use 8% — the lower end of the typical range — representing $420,000 annually. That's the cost of having an insurance carrier administer your plan rather than doing it yourself or hiring a third-party administrator directly.

Some of these costs are necessary regardless of the funding arrangement. Claims must be processed. Networks must be managed.

Key Insight

When you're fully insured, you're paying for the carrier's entire overhead structure, including costs unrelated to your group: corporate marketing budgets, executive compensation, lobbying expenses and shareholder relations. A self-funded arrangement allows you to pay only for the administrative services you actually need.

Carrier profit margin: 1% to 4%

Health insurers often cite their profit margins as proof they're not the problem. "We only make 2% to 3%," they say. "Look elsewhere for savings."

The reported numbers are accurate. The NAIC showed an overall health insurance industry profit margin of approximately 0.8% for 2024, though commercially insured segments typically run higher.

Here's what matters: even a seemingly small percentage represents significant dollars at scale.

For our 300-employee company paying $5.25 million annually, a 3% carrier profit margin means $157,500 per year goes directly to the insurance company's bottom line. Over five years, that's $787,500. Over a decade, it's $1,575,000.

But there's a more important dynamic at play. The ACA's 80/20 rule creates a structural incentive for carriers to allow healthcare costs to rise. When premiums increase, the 15% to 20% that carriers can retain for admin and profit grows proportionally in absolute dollars, even if the percentage stays flat.

[2] Kaiser Family Foundation, "Health Insurer Financial Performance in 2024," February 26, 2026.
[3] National Association of Insurance Commissioners, "U.S. Health Insurance Industry 2024 Annual Results," accessed June 15, 2026.

Consider that a carrier earning 3% profit on a $10 million premium book earns $300,000. If that premium grows to $13 million over three years (roughly 9% annual growth), the same 3% margin yields $390,000. The carrier profits more when costs rise. Their incentive is not to control costs but to ensure the 80% to 85% that must go to claims rises just enough to justify higher premiums while keeping their retained percentage constant.

This is not fraud. It's not even necessarily bad faith. It's structural. The regulatory framework rewards growth in absolute premium dollars, not efficiency.

State premium taxes: 2% to 3%

Here's a cost you're paying that you might not know exists: state premium taxes.

Fully insured health plans are subject to state premium taxes. These taxes are levied on the insurance carrier but passed through to you as part of the premium. Rates vary by state but typically range from 2% to 3% for group health coverage.

For a $5.25 million premium, that's $105,000 to $157,500 annually going to state tax authorities.

Immediate Savings Opportunity

Self-funded plans governed by the Employee Retirement Income Security Act (ERISA) are exempt from state premium taxes. If you move to a self-funded arrangement, this cost disappears entirely. Not reduced. Not negotiated down. Eliminated. That's $105,000 to $157,500 annually in savings before you touch anything else in your benefits structure. Over five years, that's $525,000 to $787,500.

Risk and contingency loads: 1% to 3%

Carriers build risk charges and contingency margins into fully insured premiums to account for claims volatility, unexpected utilization spikes and adverse selection. These loads are separate from the carrier's profit margin. They exist to protect the carrier from taking on a group that turns out to be more expensive than projected.

For larger groups with more data, these loads tend to be smaller. For smaller groups, they can be significantly higher because the carrier has less historical data to predict claims accurately.

The result: Smaller groups can see increases that have little to do with their own claims experience, driven instead by broader market and pool pressures.

The Peterson-KFF Health System Tracker analyzed 2026 rate filings and found insurers explicitly citing "ACA market morbidity deterioration" as a factor. One carrier attributed a 4% adjustment to morbidity changes: 3% from the migration of low-claims groups to self-funded products and 1% from shrinking market size.[4]

Translation: the healthier groups are leaving fully insured plans. The carriers are charging those who remain more to cover the deteriorating risk pool. If you're still fully insured, you're subsidizing this shift.

[4] Peterson-KFF Health System Tracker, "How much and why premiums are going up for small businesses in 2026," September 24, 2025.

The Complete Picture: Where Your $5.25 Million Goes

Here's the breakdown for a typical 300-employee company paying $5.25 million in annual fully insured premiums:

Category	Percentage	Dollar Amount
Medical Claims	86%	$4,515,000
Carrier Administration	8%	$420,000
Carrier Profit	2%	$105,000
State Premium Tax	2%	$105,000
Risk/Contingency Load	2%	$105,000
Total Non-Claims Costs	**14%**	**$735,000**

Non-claims loads typically range from 14% to 20% depending on group size and carrier. This illustration reflects a 300-employee group at an 86% medical loss ratio.

Approximately $735,000 per year is not going to healthcare. It's going to taxes, carrier overhead, profit margins and risk loads. Over five years, that's $3.7 million. Over a decade, it's $7.35 million.

Not all of these costs are avoidable. Some level of administration is necessary in any funding arrangement. But the question is if you could you reduce these non-claims costs by managing them differently.

Why Your Premium Keeps Rising Even When Your Employees Stay Healthy

Beyond the premium dollar breakdown, there are structural problems with remaining fully insured that compound over time.

Your premiums don't pay for your employees' claims

Here's a fundamental reality about fully insured coverage that most employers don't understand: when you pay your premium, that money goes into a pooled fund with premiums from hundreds or thousands of other employers. Your employees' claims are paid from that pool. But so are everyone else's claims.

You have no guarantee that your premium dollars are actually funding your own employees' healthcare. You could have a healthy population with low claims, but you're still paying into a pool that's covering expensive claims from other groups. You're cross-subsidizing other employers' healthcare costs with no visibility into who you're subsidizing or why.

For most employers in the 100- to 1,000-employee range, your premium is only partially based on your own claims experience. The smaller your group, the more your rate reflects the broader market, not your population. Even at larger sizes where your experience carries more weight, you're still paying state premium taxes, carrier profit margins and operating without the claims transparency that self-funding provides.

This is not how self-funded plans work. When you're self-funded, every dollar you pay goes directly to your employees' claims or to administrative services for your specific group. If your population is healthy and claims are low, you keep the savings. If claims are high, you pay more, but at least you know it's your employees' healthcare you're funding, not someone else's.

With fully insured coverage in the pooled model, you have no idea. Your $5.25 million premium could be paying for another employer's $7 million in claims while your own employees generate only $3 million. The carrier's actuaries spread the risk across the entire pool, which means high-cost groups are subsidized by low-cost groups. If you're a well-managed employer with good benefits design, strong wellness programs and a relatively healthy population, you're almost certainly subsidizing poorly managed groups.

The carrier will never tell you this. It will say that your rate is based on your claims experience, but for smaller groups, that's only partially true. The smaller your group, the more your rate reflects everyone's claims, not just your own. You're paying a blended price, not your actual price.

This cross-subsidization dynamic is why carriers are reluctant to let healthy groups leave. Every healthy group that moves to self-funding makes the fully insured pool more expensive for those who remain. The carrier loses a premium payer who was subsidizing others. The remaining groups have to absorb that cost.

The deteriorating risk pool

The fully insured market is shrinking. According to the 2025 KFF Employer Health Benefits Survey, 67% of covered workers are now enrolled in self-funded plans. Among larger firms (200 or more employees), that number rises to 80%.[5]

[5] Kaiser Family Foundation, "2025 Employer Health Benefits Survey," October 22, 2025.

This migration is not random. It's selective. Healthier groups with predictable claims move to self-funded and level-funded arrangements. Groups with volatile claims or less sophisticated financial management stay fully insured.

As the healthier groups leave, the remaining fully insured risk pool becomes more expensive. Carriers adjust their pricing accordingly. The Peterson-KFF analysis of 2026 rate filings found multiple insurers citing the migration of lower-claims groups as a factor driving premium increases for those who remain. The median proposed premium increase for small group plans for 2026 is 11%.[6]

If you're still fully insured, you're not just paying for your own employees' claims. You're cross-subsidizing a risk pool that gets more expensive every year as the best risks exit.

The lack of claims transparency

When you're fully insured, you typically receive limited claims data. You might get aggregate reports showing total claims by category. You might see high-level utilization metrics. But you don't see the level of detail that would allow you to identify cost drivers and implement targeted interventions.

You can't see which specialty providers are driving costs. You can't identify gaps in preventive care that lead to expensive downstream events. You can't analyze whether your pharmacy benefit design is optimal. You're paying the premium. The carrier has the data. And you're operating blind. Your employees pay a portion of that premium too. Without the data, you can't manage the cost or direct them to the right care. That's not just a financial gap. It's a stewardship one.

Self-funded employers have full access to their claims data. They can analyze it. They can act on it. They can design programs to address specific cost drivers within their population. Fully insured employers cannot.

The MLR perverse incentive

We mentioned this earlier, but it's worth stating plainly: the ACA's Medical Loss Ratio rules create a structural incentive for carriers to allow costs to rise.

If a carrier is required to spend 85% of premium on claims, the way to increase profits is to increase the total premium. A 3% margin on $5.25 million is $157,500. A 3% margin on $5.7 million is $171,000. Same percentage. Higher absolute profit.

The carrier doesn't make more money by controlling your costs. They make more money by allowing costs to rise, increasing your premium and taking their percentage of a larger number.

This doesn't mean carriers want your costs to skyrocket. Runaway costs hurt retention. But it does mean they have no incentive to innovate aggressively on cost containment. The regulatory structure rewards premium growth, not efficiency.

[6] Peterson-KFF Health System Tracker, "How much and why premiums are going up for small businesses in 2026," September 24, 2025.

The renewal cycle trap

Fully insured employers are locked into a 12-month renewal cycle with limited leverage. When your renewal comes in at a 10% increase, your options are the following:

1. Accept the increase
2. Shop other carriers (who are pricing the same risk pool with the same factors)
3. Shift costs to employees through higher deductibles or contributions
4. Cut benefits

None of these are strategic or sustainable solutions. They're tactics to manage an unsustainable structure.

Self-funded employers have more flexibility. They can steer employees to high-performing networks, negotiate directly with providers and use reference-based pricing to reduce facility costs. They can implement a pharmacy strategy that actually reflects their population's needs. They can deploy the right solutions for their specific workforce without carrier approval. They control the levers.

What Would a Different Funding Structure Cost You?

The alternative to fully insured coverage is not a single option. It's a spectrum. The right answer depends on your size, risk tolerance, financial position and administrative capabilities.

Level-funded plans

Level-funded plans are a hybrid. You pay a fixed monthly amount (like a fully insured premium), but the plan is technically self-funded. Your payments go into a claims fund, a stop-loss insurance policy to protect against large claims and an administrative fee.

At the end of the year, if your claims are lower than projected, you receive a surplus refund. If claims are higher, the stop-loss insurance covers the excess. Your monthly payment stays level throughout the year, giving you budget certainty.

Level-funded plans give you many of the benefits of self-funding (claims data transparency, surplus refunds, potential ERISA exemption from state premium taxes) without the cash flow volatility of traditional self-funding.

They work particularly well for employers in the 100 to 500 employee range who want to test self-funding without taking on significant cash flow risk.

Self-funded plans

Self-funded plans eliminate the insurance carrier as a middleman. You pay claims directly as they occur. You hire a third-party administrator (TPA) to process claims and manage the network and a pharmacy benefit manager (PBM) to manage your drug benefit. You purchase stop-loss insurance to protect against catastrophic claims.

Your costs are variable month to month based on actual claims, but over time, your total costs are based on your population's actual utilization, not a carrier's risk load or profit margin.

Self-funded employers have full access to their claims data. They control plan design. They can implement innovative cost containment strategies. They avoid state premium taxes. They significantly reduce or eliminate carrier profit margins.

The tradeoff is cash flow variability and the administrative burden of managing the plan. But the risk is more manageable than most CFOs assume.

How stop-loss insurance works

Stop-loss insurance is the standard protection mechanism in self-funded arrangements, and it is what protects you from catastrophic claims. There are two types:

Specific stop-loss protects against individual high-cost claimants. You set a deductible (typically $200,000 to $300,000 per person per year, depending on group size and risk tolerance.). If an employee has a $500,000 claim, you pay the first $250,000 (your specific deductible) and the stop-loss carrier pays the remaining $250,000.

Aggregate stop-loss protects against total claims exceeding your budget. If your expected claims are $2.5 million and your aggregate corridor is 125%, your maximum exposure is $3.125 million. If total claims hit $3.5 million, you pay $3.125 million and the stop-loss carrier pays the excess $375,000.

HUB runs a Monte Carlo simulation to identify the optimal specific deductible for your group — the combination of coverage and cost where you statistically come out ahead the most often.

Worst-case scenario: What happens?

Let's model the scenario CFOs worry about most: multiple catastrophic claims in the first year.

Employees	Expected Annual Claims	Specific Stop-Loss	Aggregate Stop-Loss
300	$4.5 million	$250,000 per person	125% corridor ($5.6 million max)

	Employee A	Employee B	Employee C
Event	Premature birth, NICU stay	Cancer treatment	Cardiac surgery
Total claim	$600,000	$450,000	$350,000
You pay	$250,000	$250,000	$250,000
Stop-loss pays	$350,000	$200,000	$100,000

Even in this severe scenario, specific stop-loss caps your exposure at $750,000 for these three claims. Aggregate stop-loss provides a separate layer of protection: if your total claims across all employees for the year exceed $5.6 million — 125% of your $4.5 million expected claims — the stop-loss carrier covers everything above that threshold.

$750,000

Max out-of-pocket on three catastrophic claims

Compare this to fully insured

Under a fully insured plan with the same claims experience, your carrier would simply increase your renewal 15% to 20% the following year to recapture those losses plus a risk load. You don't avoid the cost. You just pay it later, with a markup.

The difference with self-funding is you see the claims in real time, understand what drove them and can implement programs to prevent similar events in the future. With fully insured, you get a renewal increase and a vague explanation about "claims experience."

For employers with more than 500 employees and strong internal capabilities, self-funding is often the most cost-effective option. For those between 100 and 500 employees, level-funding provides many of the same benefits with more predictable monthly cash flow.

Group captive insurance

A group captive is a risk-sharing arrangement where multiple employers pool their self-funded plans to spread risk. Each employer remains self-funded but participates in a captive insurance company owned collectively by the member employers.

Captives provide cost stability (through the pooling mechanism), claims transparency (you still see your own data), and the potential for underwriting profit (if the captive performs well, members share in the surplus).

They work well for employers who want the benefits of self-funding but prefer to share risk with other similarly situated companies rather than relying entirely on commercial stop-loss insurance.

How much can you save?

Industry analyses consistently show employers moving from fully insured to self-funded arrangements typically save 5% to 8% on total healthcare costs. For a $5.25 million premium, that's $262,500 to $420,000 annually.

The savings and transparency come from multiple sources:

- Elimination of state premium taxes (2% to 3%)
- Elimination of carrier profit margins (1% to 4%)
- Reduction in administrative costs by selecting a more efficient TPA and PBM
- Reduction in risk and contingency loads by having your own claims data
- Improved cost management through access to actionable claims data
- Full claims data transparency, enabling targeted interventions that reduce costs over time

Not every employer will see the full 5% to 8% savings. Results depend on your claims experience, plan design, stop-loss costs and how effectively you use your claims data. But the structural advantages are real.

The question is not whether alternatives exist. They do. The question is whether your current advisor has presented them to you in a way that allows you to make an informed decision.

How to Know If You're Ready

Not every employer should move away from fully insured coverage. For some groups, fully insured is the right answer. But if you've never evaluated the alternatives, you're making a decision by default, not by design.

Here are five questions to ask yourself:

1. Do you have at least 100 enrolled employees?

This is the general threshold where alternative funding becomes viable. Below 100, stop-loss insurance premiums and TPA fees may offset the savings. Above 100, the economics typically work.

2. Has your renewal increased more than 8% in each of the last two years?

What has your renewal increase been over the last two years? If it's been above 8%, you're paying for a deteriorating risk pool, not just your own claims. If it's been below 8%, you're likely a well-managed group — and fully insured, you're subsidizing everyone else's costs without capturing any of that value yourself.

3. Do you have claims data visibility?

If you can't tell which conditions are driving costs, which providers are most efficient or where gaps in care exist, you're flying blind. Self-funded plans give you the data to manage proactively.

4. Has your broker presented alternatives beyond switching carriers?

If your renewal conversation is always "here's your increase, let's shop it," your broker is operating as a transaction processor, not a strategic advisor. Strategic advisors present funding alternatives, not just carrier alternatives.

5. Are you comfortable with some level of budget variability in exchange for long-term savings?

Self-funding introduces month-to-month claims variability. If your organization requires absolute budget certainty, level-funded plans or fully insured coverage may be better fits. If you can tolerate variability in exchange for lower total costs and better data, self-funding may be optimal.

If you answered yes to the first four questions and are open to exploring the fifth, you should at least model what alternative funding would look like for your group.

What a funding structure conversation looks like

A carrier-shopping conversation and a funding structure conversation are two different things. One asks which insurer prices your risk most competitively this year. The other asks whether your current funding structure is the right one at all. Here is how to tell which conversation you have been having:

- Has your advisor presented funding structure options or only carrier alternatives?
- Does your renewal process start with your funding structure or with carrier quotes?
- Do you have access to your claims data at a level that would let you identify your top cost drivers?
- Can you trace each component of your premium dollar to a specific cost category beyond “claims” and “administration”?
- Has your benefits strategy evolved in the last three years or has it been the same approach with a new price?
- Have you ever received a proposal that compared funding structures, not just carriers?

If your renewal conversations have stayed in carrier-shopping territory, you have been making a fully informed decision about one variable: which insurer prices the risk. You have not yet had the conversation about whether the structure itself is the right one for your organization. That conversation is available to you.

Two Trajectories: What Five Years of the Same Structure Costs and What Five Years of a Different One Won’t

You’ve seen the data. You understand the structure. You know alternatives exist. But here’s what actually matters: what does staying fully insured cost you compared to moving?

Not in theory. In dollars. Over time.

The fully insured trajectory

Let’s return to our 300-employee company paying $5.25 million today. Industry data shows fully insured renewals averaging 9% to 11% annually, driven by medical trend and the deteriorating risk pool.’[7]

If you renew at 9% annually for five years:

Year	Annual Premium	Cumulative Total
Year 1	$5,250,000	$5,250,000
Year 2	$5,722,500	$10,972,500
Year 3	$6,237,525	$17,210,025
Year 4	$6,798,902	$24,008,927
Year 5	$7,410,803	$31,419,731

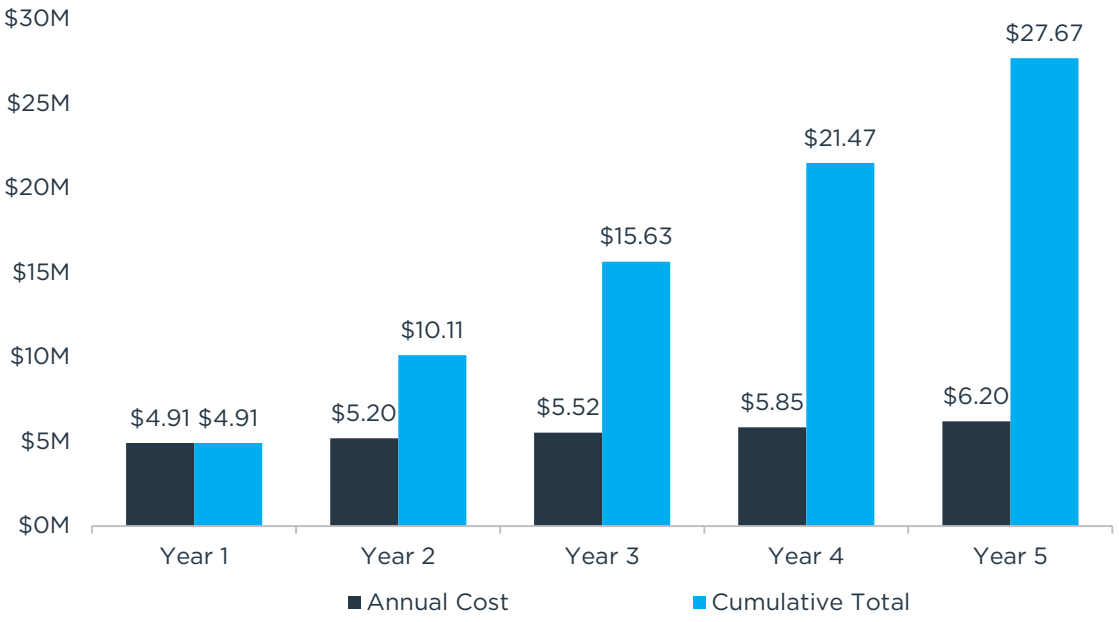
Five-year total	Year 5 annual	Total Increase from Year One to Year Five
$31,419,731	**$7,410,803**	**41%**

By year five, you're paying $7.4 million annually, a 41% increase from where you started. That's not sustainable. At some point, you shift costs to employees, cut benefits or both. This is not a strategy. It's managed decline.

The alternative funding trajectory

Now assume you move to a level-funded or self-funded arrangement. Using the midpoint of the typical savings range, you reduce costs 6.5% immediately by eliminating state premium taxes, carrier profit margins and excessive risk loads. Your effective starting point is $4,908,750.

You'll still see annual increases driven by medical trend, but you're insulated from risk pool deterioration and you have claims data to drive targeted interventions. Based on HUB's Actuarial Team's recent data, assume 6% annual increases to get the following:



Five-year total	Year 5 annual	Total Increase from Year One to Year Five
$27,671,080	**$6,197,080**	**26%**

[7] Peterson-KFF Health System Tracker, "How much and why premiums are going up for small businesses in 2026," September 24, 2025.

The bottom line is a $3.75 million difference over five years.

That's $3.75 million saved not by cutting benefits or shifting costs to employees, but by changing your funding structure and managing costs with better data. The gap widens over time as the compounding effect of lower base costs and better trend management creates increasing separation from the fully insured trajectory.

The compounding effect of inaction

The gap widens over time. By year five, your annual cost under the fully insured trajectory is $7.4 million. Under alternative funding, it's $6.2 million. That's a $1.2 million annual difference in year five alone.

If you wait three years to make this change, you have already spent $17.2 million fully insured when you could have spent $15.6 million. That's $1.6 million you will not get back. And you are starting the transition from a higher base, which means your future savings are smaller.

This is why the decision to evaluate alternatives matters now, not at your next renewal or the one after that. Every year you wait compounds the cost.

The employers who consistently pay less for healthcare don't just make one good decision at renewal — they assess their funding structure every year, with a team that has the actuarial depth to model their specific population.

That discipline creates options. If the analysis points to a transition, they capture the savings. If it confirms they're well-positioned, they have real leverage to negotiate their fully insured renewal. See what a different structure would cost for your specific group. Request your Funding Strategy Assessment.

What about risk?

The question we hear most often: "What if we have a catastrophic claims year? Won't we be worse off?"

Here's the reality: stop-loss insurance protects you against large claims. A typical stop-loss policy includes:

- **Specific stop-loss**: Covers individual claims above a certain deductible (often $200,000 to $300,000 per person per year).
- **Aggregate stop-loss**: Covers total claims if your group's overall claims exceed 125% of expected costs.

In a worst-case scenario where multiple employees have $500,000 claims, your stop-loss coverage kicks in. You pay the deductible (which is built into your cost model) and the stop-loss carrier pays the rest.

The difference between fully insured and self-funded is not whether you're protected against catastrophic claims. You are. The difference is:

1. **Fully insured**: You pay for that protection every year through built-in risk loads and pooling charges, regardless of whether you use it.
2. **Self-funded**: You buy stop-loss coverage based on your group's specific risk profile and you only pay claims up to your stop-loss deductible.

Stop-loss is not perfect. If your group's claims consistently exceed projections, your stop-loss premiums will increase over time or carriers may implement lasers on specific high-cost individuals. The same claim experience would drive your fully insured premiums higher too. The key difference is visibility: With self-funding, you see the claims driving the costs and you can act on them. With fully insured coverage, you're blind.

The real risk is staying still

The biggest risk is not claims volatility. It's locking yourself into a funding structure that guarantees you'll overpay by 5% to 8% every year, with no visibility into where the money is going and no ability to manage it strategically.

You Have the Data. Here Is What to Do With It

You're reading this white paper because your health insurance costs are a problem. They're too high. They're growing too fast. And you're not sure what to do about it.

The data in this document shows you why costs are high and where the money is going. But data alone doesn't solve the problem. The question is what are you going to do differently?

Most employers do nothing. They get frustrated at renewal. They accept the increase. They shift costs to employees. And they repeat the cycle next year.

A smaller group of employers asks their broker to shop the market. They get quotes from three or four carriers. They might save 2% to 3% by switching. But cost that comes with switching carriers is real, and there are only so many carriers to cycle through. And either way, they're still fully insured. They're still paying state premium taxes. They're still contributing to carrier profit margins. They're still subsidizing a deteriorating risk pool. They've changed carriers, not funding structures.

The employers who actually solve the problem take a different approach. They evaluate their funding structure. They model alternatives. They ask hard questions of their advisors. They make decisions based on data, not inertia.

You've invested time reading this document. You know where your premium dollar goes. You know the structural problems with staying fully insured. You know alternatives exist.

Do you know what they would look like for your company specifically?

We can show you. Not in theory. Not in generalizations. With your actual data. Your claims. Your demographics. Your plan design. We'll model what level-funded, self-funded and group captive arrangements would look like for your group. We'll show you the savings potential. We'll show you the tradeoffs. We'll answer your questions.

We'll provide the analysis. You decide what makes sense.

If you're paying more than $500,000 in annual premiums and you've never seen a real alternative funding analysis, you have not yet had the conversation your renewal costs are asking for. That conversation starts with a HUB Funding Strategy Assessment, and it costs you nothing but an hour.

NEXT STEPS

Request your HUB Funding Strategy Assessment

The HUB Funding Strategy Assessment models your actual premium against both a fully insured and an alternatively funded trajectory, year by year, so you can see your fully insured cost path, your alternative funding path and where the gap between them opens up, against your own numbers, before you make any decision.

That includes a direct look at transition considerations specific to your group, so the question in front of you is not just what the savings could be, but what the path to get there actually looks like for your situation.

HUB combines the resources, carrier relationships and alternative funding expertise of a national consultancy with local teams who stay closely involved in execution. That means your assessment is grounded not just in projections, but in real-world experience helping employers evaluate and transition funding strategies in volatile renewal environments.

Request your **funding strategy assessment**

Contact a HUB Advisor at hubinternational.com

HUB Funding Strategy Assessment

Most leaders at fully insured employers know their renewal went up. Fewer know why, specifically, and which part of that increase was unavoidable.

The HUB Funding Strategy Assessment models your fully insured trajectory against realistic alternatives, so you leave with a clear read on your options and the numbers behind them.

Request Your Funding Strategy Assessment

Ready for tomorrow.

Risk & Insurance | Employee Benefits | Retirement & Private Wealth