HUB

Risk & Insurance | Employee Benefits | Retirement & Private Wealth

COST MANAGEMENT WEBINAR SERIES

Beyond Fully Insured:

Alternative Benefits Funding Strategies for Small- and Mid-Sized Employers

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Agenda

1. The Fully Insured Market
2. Understanding Self-Funding
3. Level-Funded Plans
4. Medical Stop-Loss Captives
5. Reference-Based Pricing
6. Putting it All Together

The Fully Insured Market

What's happening in the fully insured market – and why it matters

Employer Premiums Are Accelerating

$26,993

Average family premium in 2025

6%

Family premium increase YoY

26%

5-year cumulative premium increase

Context:
Premium growth of 6% outpaced both wage growth (4%) and inflation (2.7%). Over the past five years, family premiums have risen 26% — roughly in line with inflation (23.5%) but signaling sustained pressure on employers and employees alike.

> *"Employers have nothing new in their arsenal that can address most of the drivers of their cost increases."*
>
> *— Drew Altman, President & CEO, KFF*

KFF 2025 Employer Health Benefits Survey (October 2025)

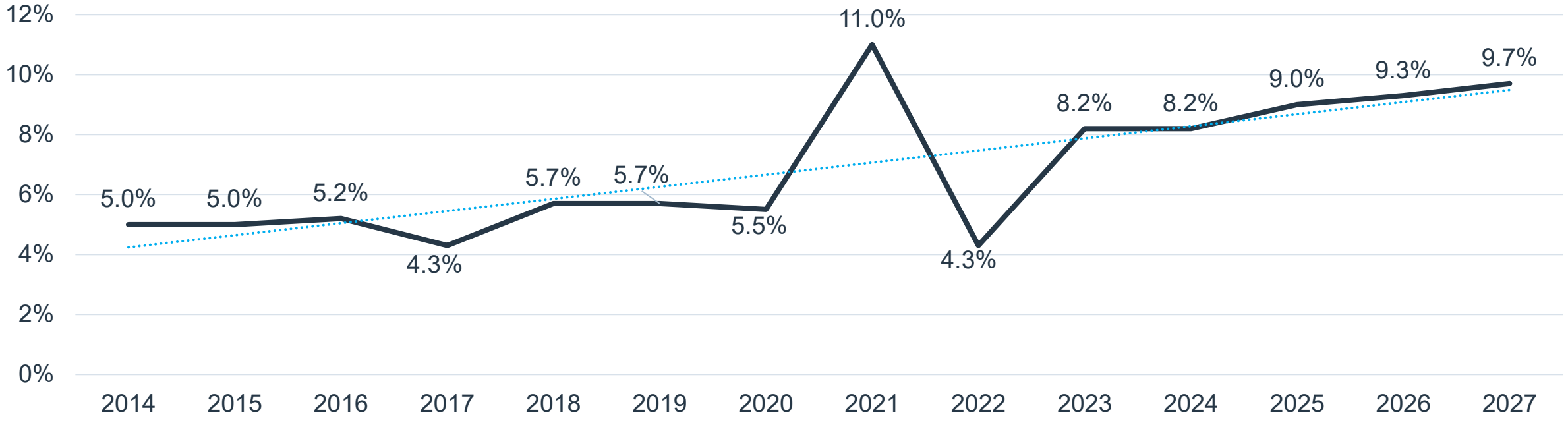
Historic Trend

Phase 1:
4-6% pre-COVID

Phase 2:
COVID outliers

Phase 3:
Trends have settled into a new normal: 8–10% & steadily growing

Combined Med/Rx Trend[1]

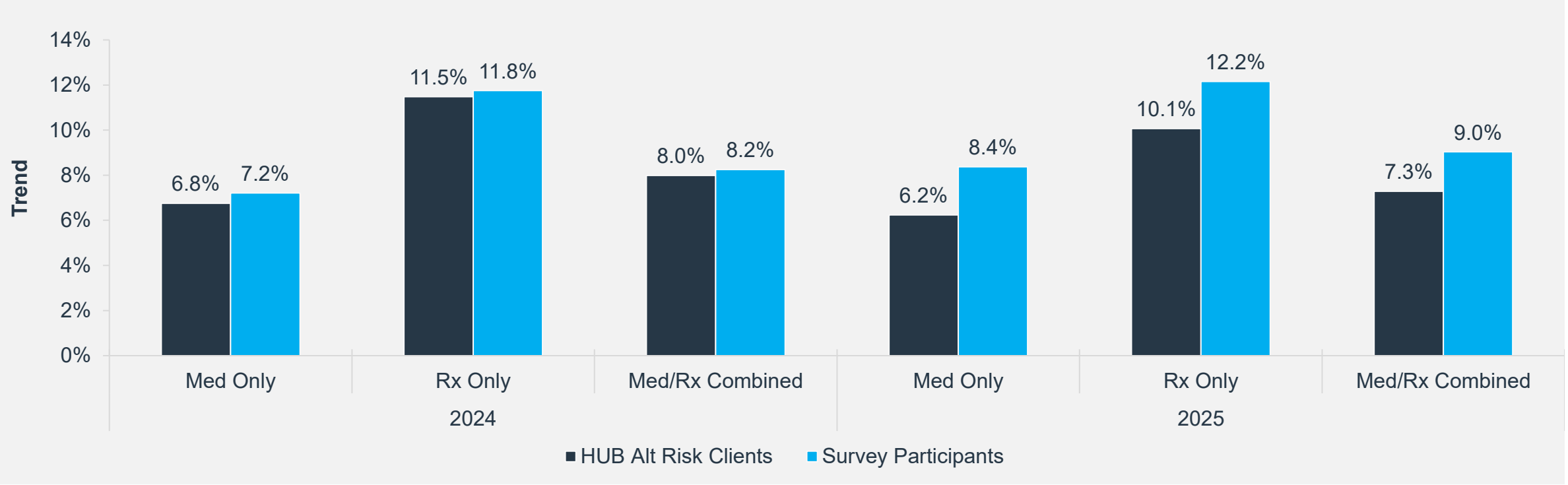


Source: 2027 HUB Benefits Cost Trends Report

[1] 2014–2025 are actual trend patterns, while 2026 and 2027 are projected.

Alternative Risk is Consistently Lower

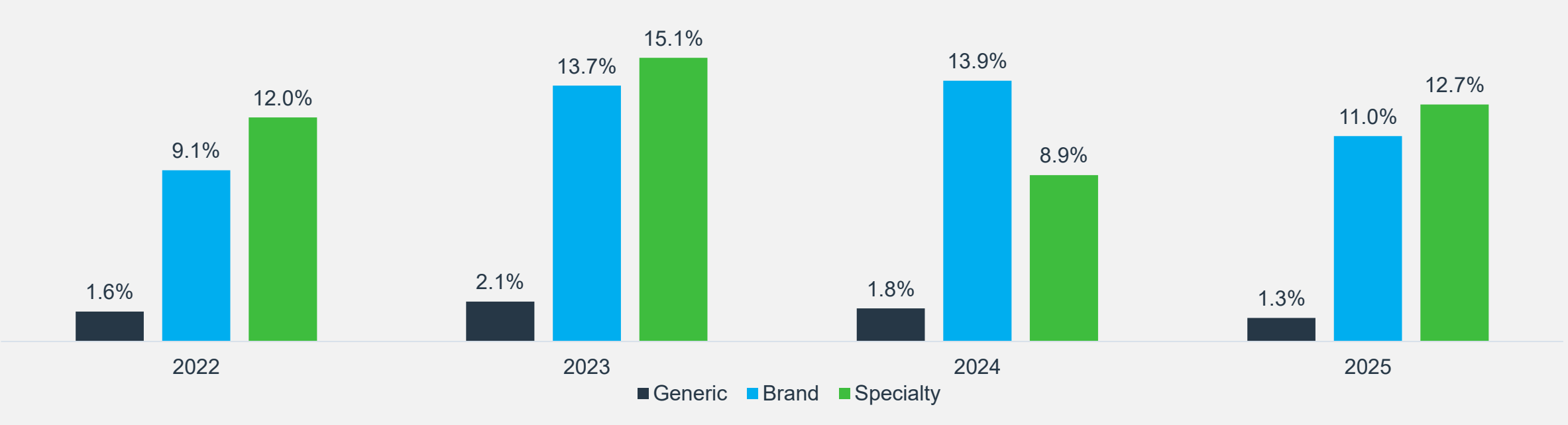
- Survey participants provided commercial block
- HUB data is based on self-funded clients



Source: 2027 HUB Benefits Cost Trends Report

Rx Trends by Category

- Generics remained stable
- Brand is heavily shaped by GLP-1s
- Specialty is the most volatile, driven by new therapies, expanded indications and biosimilar disruption



Source: 2027 HUB Benefits Cost Trends Report

What's Driving Healthcare Costs

#1 & Rising

Cancer & Mental Health

Leading Drivers of Healthcare Spend

Advances in cancer treatment are improving outcomes while increasing treatment complexity and cost. Mental health influences utilization across nearly every dimension of health plan performance, creating sustained clinical and financial impact.

35%

Precision Therapies

Targeted Oncology Approvals

Precision therapies are redefining the future cost landscape. While these therapies affect relatively few members today, they create significant plan level financial exposure and reinforce the importance of proactive clinical and financial planning.

+11.4%

Pharmacy Trend

Innovation Driving Growth

Therapeutic innovation, specialty medications, and expanding clinical indications continue to accelerate pharmacy trend and reshape employer healthcare costs.

42%

GLP-1 Medications

Current FDA-Approved Clinical Indications

A substantial portion of the employer-sponsored population are eligible for GLP-1 therapy. Expanding indications will further increase long-term pharmacy and utilization impact.

Sources: PwC Health Research Institute Medical Cost Trend (2025); Exploration of Targeted Anti-tumor Therapy, FDA 2025 Cancer Drug Approvals (Apr 2026); EBRI Issue Brief, GLP-1 Coverage and Its Impact on Employment-Based Health Plan Premiums (Oct 2025), citing Peterson-KFF Health System Tracker (Sept 2024); McKinsey "What to Expect in US Healthcare" (Jan 2026)

Alternative Funding Strategies and Risk Profiles

Third-Party Risk Transfer

Risk is transferred to a carrier or PEO via co-employment

PEO

- Co-employment
- Access to master health plan
- Employer offloads HR & benefits admin
- HUB-curated national PEO partners
- 5–~150 employees

Fully Insured

- Carrier bears 100% of risk
- Guaranteed fixed premium
- Rates set prospectively
- Minimal plan design flexibility
- Limited claims data access

Partial Risk Retention

Some risk is retained by the plan and some is transferred to the stop loss carrier

Non-BUCA Level Funded

- Monthly fixed installments
- Year-end surplus potential
- Full claims transparency
- Non-carrier plan administration
- 50–~500 employees

Medical Stop Loss Captive

- Self-funded + stop loss protection
- Shared risk pool with other employers
- Full claims data ownership
- Carrier-level stop loss pricing
- ~100–~1,500 employees

True ASO Self-Funded

- Employer bears full claims liability
- Maximum plan design flexibility
- Complete data + network control
- Carve-out programs available
- 100+ employees

← Lowest Complexity — Higher Transparency, Control & Potential Return →

ICHRA offerings with a group health plans (EE classification/carveouts) must meet specific and certain rules and subject to limitations – see your Compliance Practice Lead

Understanding Self-Funding

What Changes When You Move Beyond Fully Insured

	Fully Insured	Alternative Funding
Financial Model	Fixed premium Carrier assumes financial risk Limited financial flexibility	Claims-based funding Stop-loss limits catastrophic exposure Opportunity to retain savings
Clinical Insights	Limited visibility between renewals Limited insight into cost drivers No member-level clinical visibility	Actionable claims visibility Member-level clinical insight Ongoing cost trajectory monitoring
Strategic Decisions	Respond at renewal Negotiate or change carriers Modify benefit strategy	Identify emerging risk early Address emerging risks before renewal Make informed funding decisions

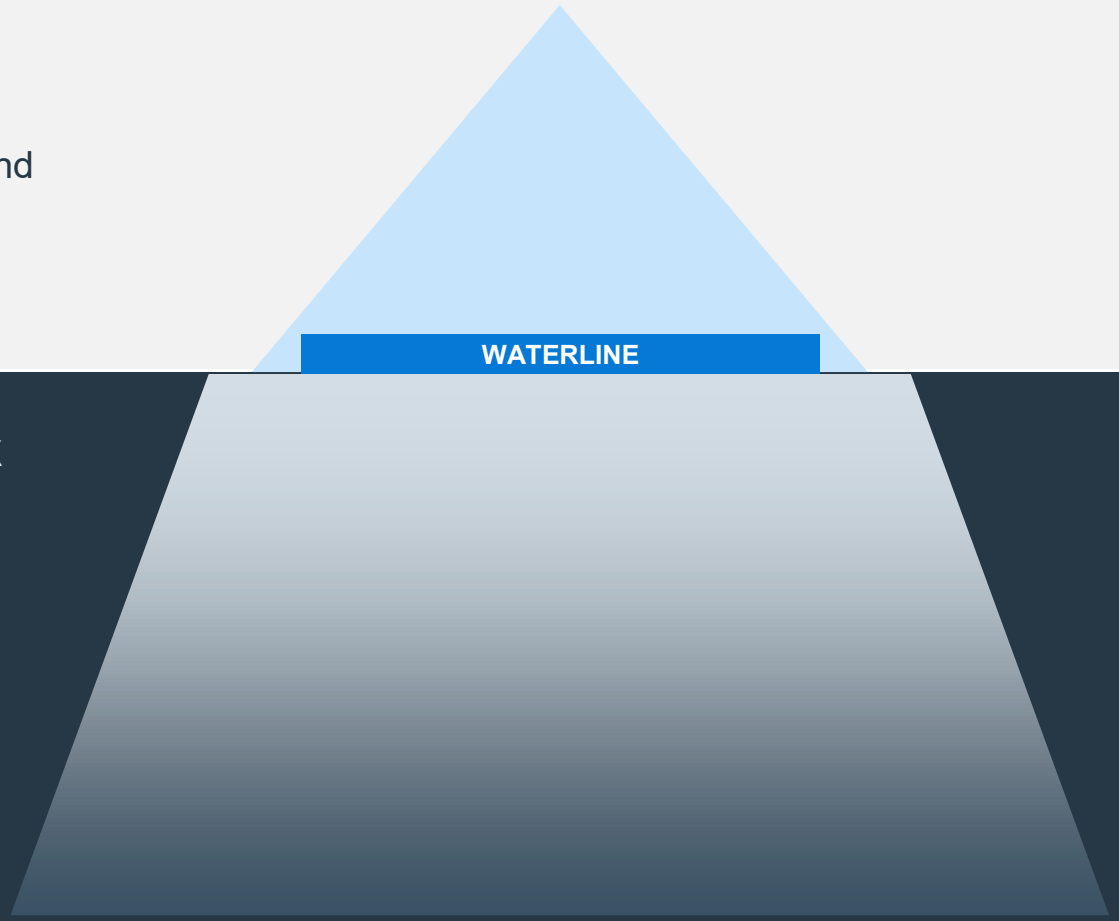
Clinical insight becomes a strategic advantage once an employer assumes financial risk.

Clinical Visibility in Alternative Risk

Reported Results

Claims reports and PMPM spend
Known high-cost claimants
Carrier renewal rates

Traditional Reporting



Underlying Clinical Risk

Emerging risk
Care gaps
Escalating trajectories
Stop-loss exposure
Treatment appropriateness
Catastrophic risk

Clinical Insight

Factors influencing future cost and outcomes.

Risk is Not a Claim. It’s a Population.

Most of it is silent. All of it is measurable.

Emerging Risk	Gaps in Care	Escalating Risk	Catastrophic Event
Early Signals	**Care Patterns**	**Utilization Patterns**	**Clinical Impact**
Behavioral and clinical indicators of future risk.	Diagnosed conditions not managed to evidence-based standards.	Risk progressing into increased utilization, complexity, and cost.	Risk is a measurable clinical and financial outcome.

Risk is a continuum. Most of it never appears on a report.

Six Proven Strategies

Each approach addresses different cost drivers, risk tolerances, and workforce needs.

Non-BUCA Level Funded

Fixed monthly costs with claims transparency and refund potential — outside the big four carriers.

Medical Stop Loss Captive

Pool risk with like-minded employers for rate stability, transparency, and profit sharing.

Reference-Based Pricing (RBP)

Transparent provider pricing tied to Medicare benchmarks — 20–40% savings on facility costs.

Access to Care

Primary care, unlimited telehealth, Rx, and mental health at an affordable PEPM.

ICHRA

Employer-funded individual coverage HRAs that let employees choose their own health plan on the open market.

PEO

Outsource HR, payroll, and benefits administration through a co-employment model with access to large-group benefits.

Level-Funded Plans

A predictable entry point into alternative funding

Non-BUCA Level Funded – How it Works

01 Hybrid Funding

Fixed monthly payment covers expected claims plus stop loss — not BUCA-underwritten. Employer controls the structure.

02 Independent Markets

Placed with regional TPAs and specialty stop loss carriers — bypassing BUCA overhead and administrative load.

03 Full Transparency

Employer receives actual monthly claims data. You see what you're paying for — BUCAs almost never allow this.

Why Non-BUCA Level-Funded Wins the Conversation

10–30%

Typical savings vs. BUCA fully insured pricing for healthy groups

$0

Surplus Refund

Unused claims reserves returned to the employer at year-end — the carrier never keeps them.

Real Claims Data

Monthly reporting gives you what BUCA plans won't — actual cost drivers and intervention opportunities.

Flexible Plan Design

Network, Rx, benefit tiers — all configurable around your workforce, not the carrier's preferred structure.

HUB

HUB Advantage

Access to non-BUCA markets, stop loss expertise, and full Alt Risk Practice support — most brokers can't match this.

Medical Stop-Loss Captives

Pool risk, share in underwriting surplus, gain control

What is a Captive?

- A captive is a group of like-minded employers that pool medical stop loss risk and leverage their collective buying power for better rates, terms, and conditions.

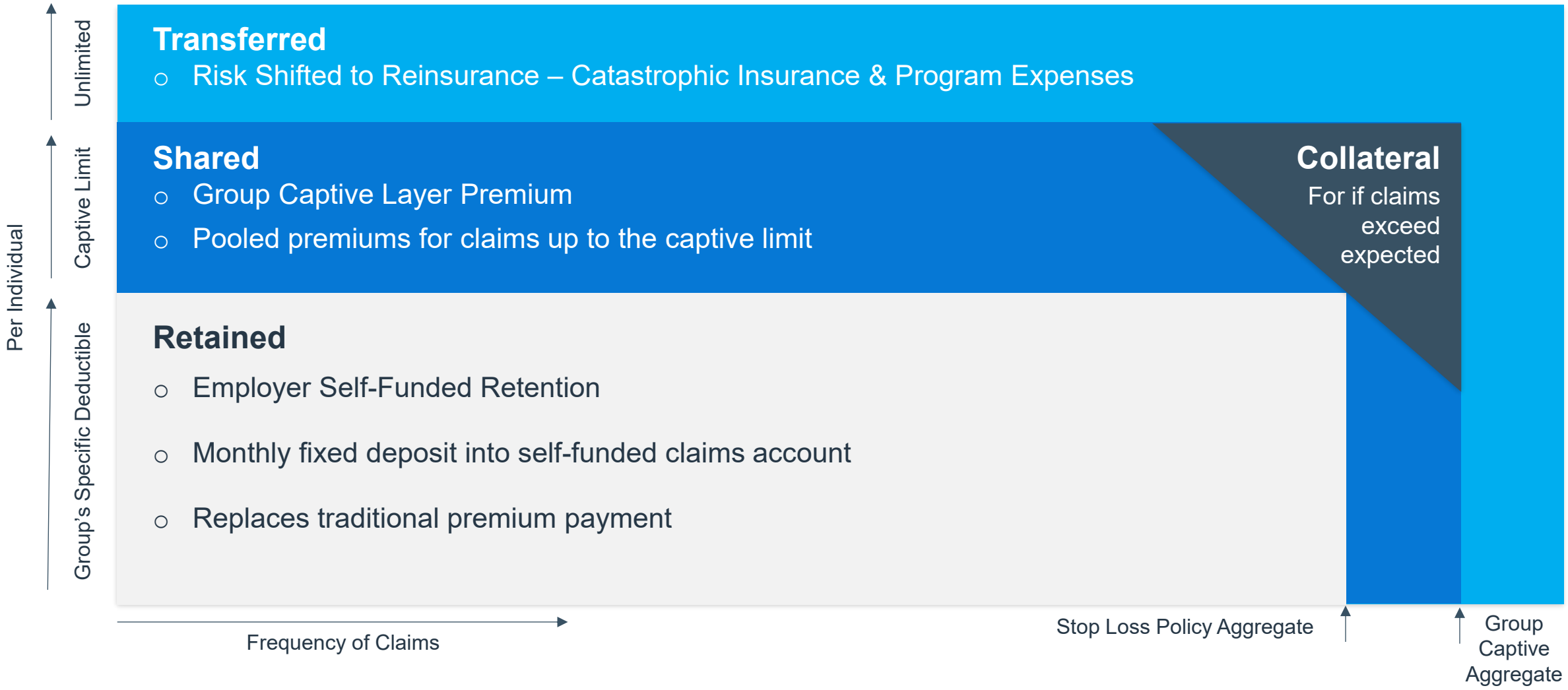
This approach provides:

Shared Risk
among the participating employers

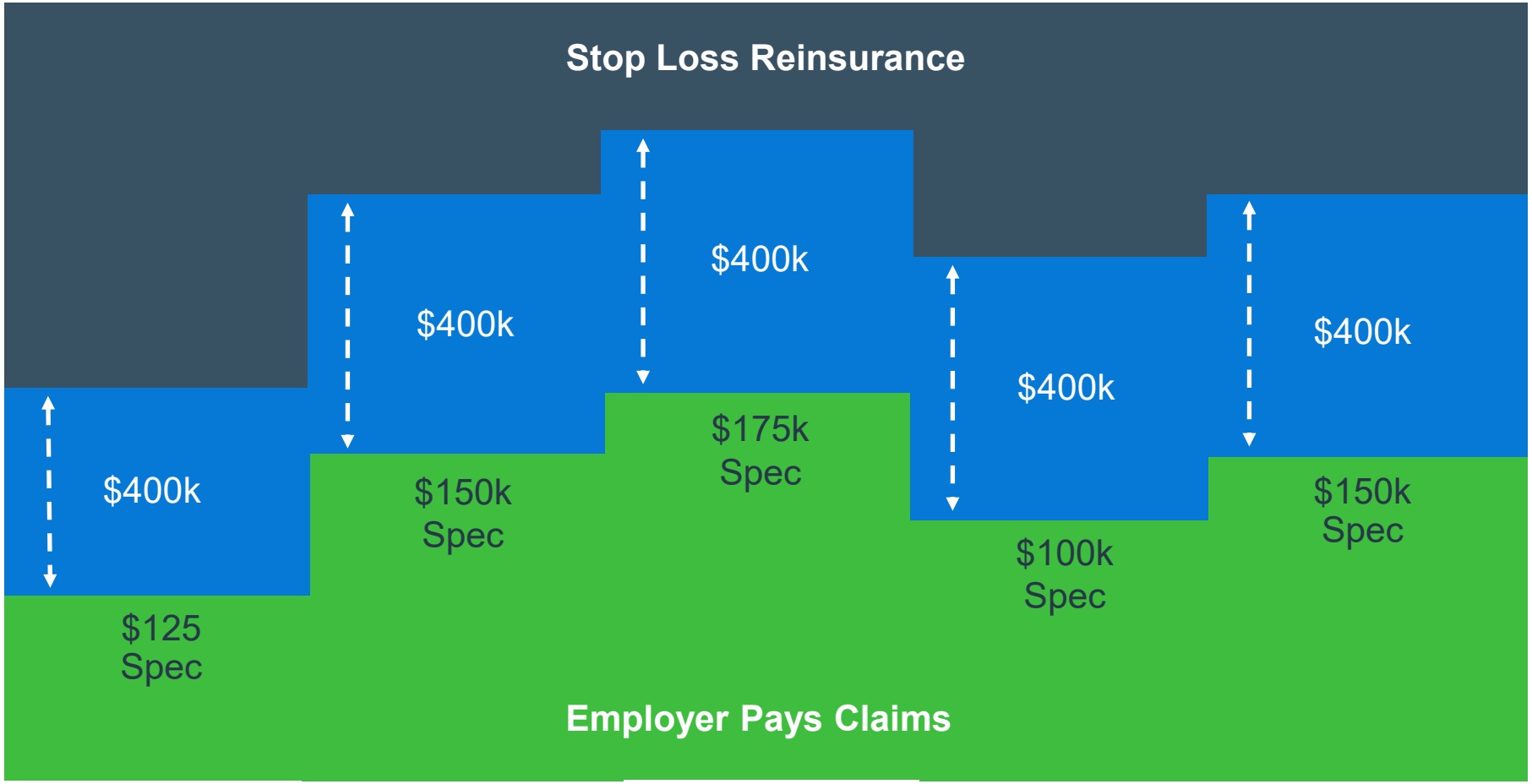
Greater Control
over insurance decisions and coverage

Significant potential
Cost Savings
through better risk management

Medical Stop-Loss Captives – The Layers



The Captive Financial Big Picture – Example



The pool purchases Reinsurance from a carrier for remaining expense.

Members share the next $400k of claim expense.

Each employer selects desired specific deductible

How Group Captives Handle Large Individual Claims

Scenario

$750,000
large claim;
$100,000
specific Stop-Loss deductible for Client

Excess Layer:
Funded by a portion of all groups' stop loss premiums

$350,000
(Reinsurer Pays)

Captive Layer:
Funded by a portion of all groups' stop loss premiums

$300,000
(Captive Pays)

Employer Layer:
Funded by client per their specific stop loss deductible

$100,000
(Employer Pays)

Large Individual Claim

How Captives Manage Aggregate Claims

Scenario

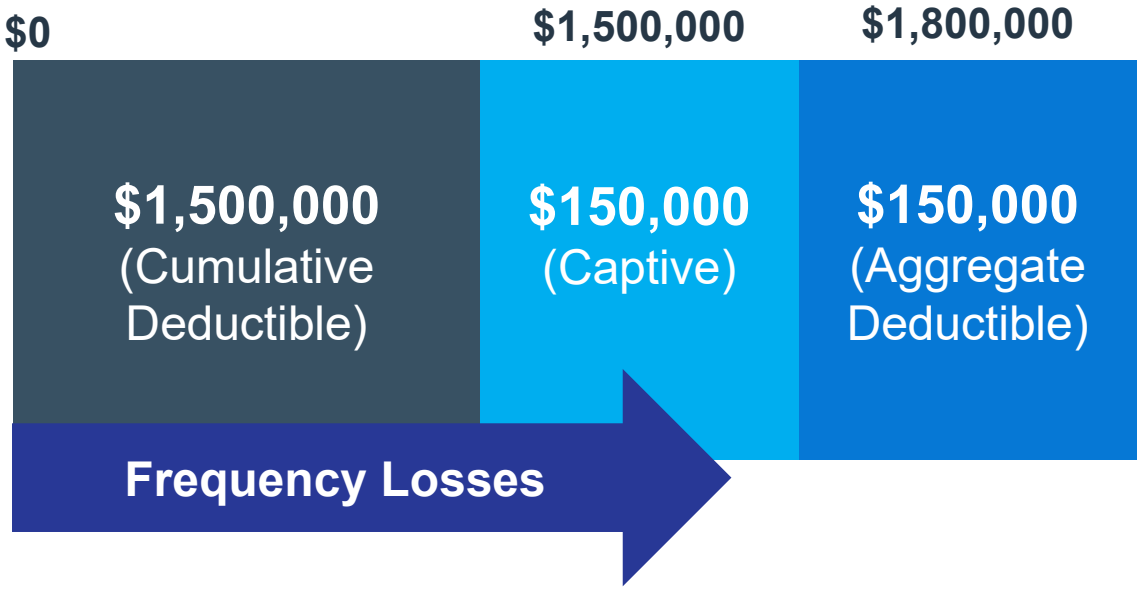
A company experiences a year with many low/mid dollar claims, resulting in accumulated expenses within their Stop Loss policy's aggregate deductible layer.

Stop Loss Policy:

Deductible: **$50,000** per covered member

Captive Layer: **$150,000**

Aggregate Attachment Point: **$1,500,000**



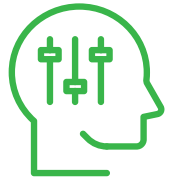
Bottom Line:
Captives help protect against the financial strain of multiple smaller claims by activating stop loss insurance once the aggregate threshold is met.

Green Light for Captive Fit

Stable employee population with consistent enrollment

CFO + HR alignment on long-term healthcare cost strategy

Employer has history of using cost-containment tools



Open to adjusting program features to influence behavior

Employer asks about governance and decision rights

Claims data available and actively reviewed

Leadership interest in data, transparency, and vendor performance

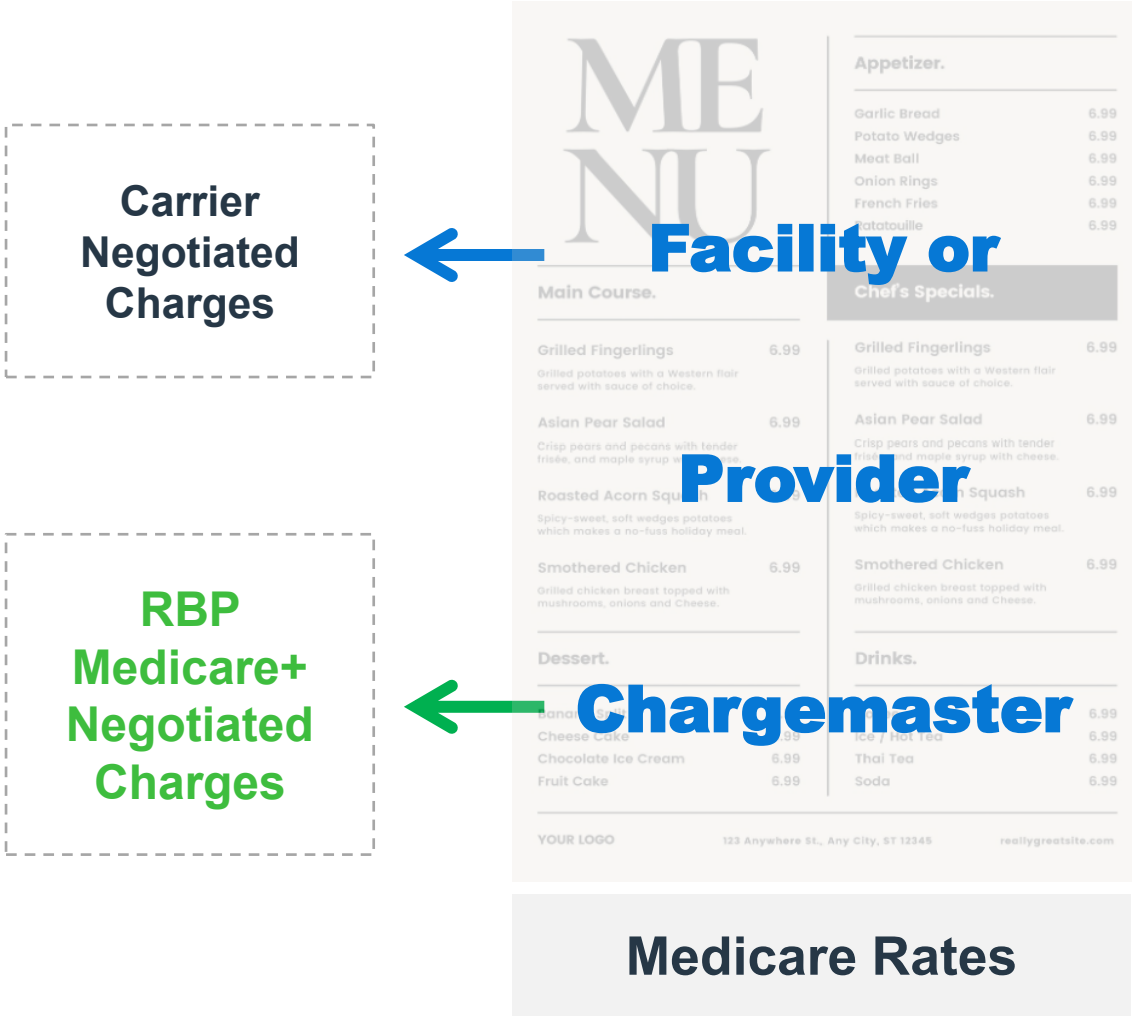
Willingness to explore multi-year strategy, not just year-one savings

Reference-Based Pricing

Meaningful claims savings beyond traditional network limitations

Reference-Based Pricing – How it Works

- A **chargemaster** (also called a Charge Description Master or CDM) - hospital's master price list for every billable service
  - Facilities contain 10,000 to 45,000+ line items
  - Providers - usually CPT codes
- **It's the "sticker price"**
- Insurance companies negotiate discounts **off chargemaster rates**
- Medicare/Medicaid pay according to their own fee schedules
- **RBP begin with Medicare Rates and add a percentage** and bypass the Chargemaster



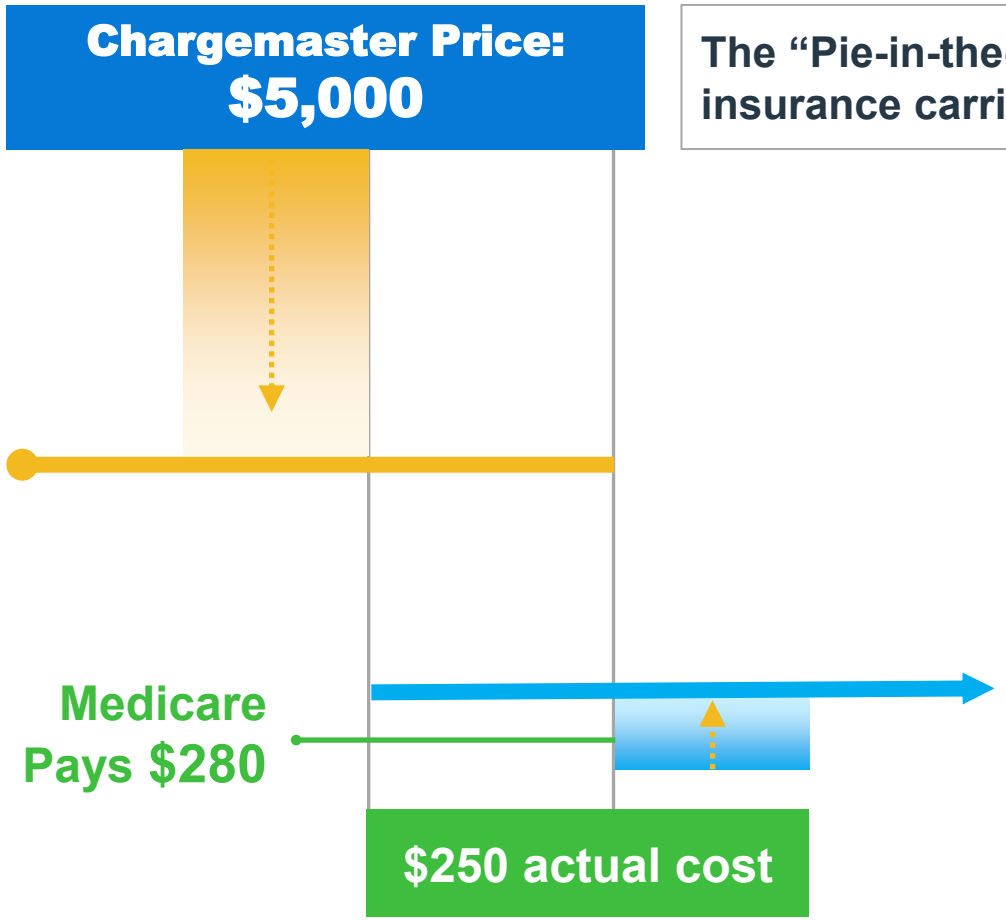
Reference-Based Pricing Claims Pricing

Using cost and Medicare data to determine a fair price for care.

SAMPLE CLAIM

BUCAs apply a **standard discount** to this marked-up price. In this case, the discount is **50%**.

BUCA clients pay
$2,500



The "Pie-in-the-Sky" price. A rate based on insurance carrier contracts

RPB clients generally pay the Medicare rate plus a pre-determine percentage

Example:
cost of care **+12%** or Medicare **+20%**, whichever is higher.

Misconceptions Around Member Abrasion Persist

National Survey of Brokers and Consultants		
	97% of survey respondents	**Actual trends**
Denial of service rates	**10 - 12%**	**0.2%**
Facility balance bill rates	**21 - 25%**	**3.0%**

Putting it All Together

The Questions Traditional Reporting Can't Answer

1

Clinical Risk Signals

What risk is my population carrying?

New diagnoses

Medication starts

Escalating utilization

Care gaps

Specialist involvement

2

Financial Exposure

What is the anticipated impact?

High-cost trajectory

Stop-loss exposure

Renewal impact

Projected spend

Budget impact

3

Strategic Options

What should we do before renewal?

Clinical engagement

Benefit strategy

Funding strategy

Renewal positioning

Risk mitigation

Reporting explains the past. Clinical consulting prepares for what's next.

Key Takeaways

Alternative funding is within reach	The strategies large corporations have used for decades are increasingly accessible to employers with 50-1,500 employees. The question is fit, not eligibility
Financial and clinical work together	The most powerful benefits decisions combine actuarial data with clinical insight. That integrated capability is what separates a strategic advisor from a transactional one.
The earlier you engage, the better	Strategy selection, data gathering and stop-loss structuring all take time. Employers who start the conversation early have more options and more leverage.
This isn't right for everyone	A knowledgeable advisor who steers you away from a solution is acting in your best interest – not demonstrating a gap in capability. Readiness matters.

Q&A

Thank you

APPENDIX

Glossary of Terms

- **ACA (Affordable Care Act)** — Federal law enacted in 2010 establishing employer mandate requirements, coverage standards and market rules that govern how employers with 50 or more full-time equivalent employees must offer health coverage.
- **Access to Care** — Programs and strategies that create practical, accessible pathways to care for employees — removing common barriers such as high out-of-pocket costs, long wait times, and the need to take time away from work. Typically includes primary care, telehealth, pharmacy, and behavioral health at an affordable per-employee per-month cost.
- **Actuarial services** — Risk assessment and financial modeling performed by credentialed actuaries. In self-funded and captive arrangements, actuarial services analyze historical claims data, develop pricing models and projections, set retention levels, and calculate collateral requirements.
- **Aggregate stop-loss** — A stop-loss insurance provision that caps an employer's total claims liability for the plan year. Once total claims exceed a defined threshold — typically 110–125% of expected claims — the stop-loss carrier covers the excess.
- **ASO (Administrative Services Only)** — An arrangement in which an employer self-funds its health plan and contracts with a carrier or TPA solely for administrative services — claims processing, network access and reporting — without purchasing insurance risk.
- **BUCA** — Acronym for the four largest national insurance carriers: Blue Cross Blue Shield, UnitedHealthcare, Cigna, and Aetna. Used to distinguish traditional fully insured and carrier-administered self-funded arrangements from independent or non-BUCA alternatives.
- **Captive (see medical stop-loss captive)**
- **Captive Manager** — The day-to-day administrator and strategic advisor for a medical stop-loss captive, responsible for captive operations and compliance and serving as liaison between the employer, TPA, stop-loss carrier, and other program participants.
- **Chargemaster (CDM)** — A hospital’s master price list — also called a Charge Description Master — for every billable service, with facilities ranging from 10,000 to 45,000+ line items. The chargemaster is the ‘sticker price’ before carrier-negotiated discounts or Medicare-based reimbursement are applied.
- **Claims lag** — The delay between when a medical service is rendered and when the claim is submitted and processed. New self-funded plans often appear favorable in year one due to claims lag — costs from the prior plan year may not yet have been filed.
- **Collateral** — Funds deposited by captive members to cover claims that exceed expected levels. In programs that perform well, employers may receive a dividend on surplus collateral at year-end — one of the few structures where favorable performance translates directly into employer return.

Glossary of Terms

- **Employer mandate** — The ACA requirement that employers with 50 or more full-time equivalent employees offer minimum essential coverage to full-time employees or face potential tax penalties.
- **Fully insured plan** — A traditional health plan in which an employer pays a fixed premium to an insurance carrier, which assumes all financial risk for claims. Unused premium is retained by the carrier regardless of claims performance.
- **GLP-1 medications** — A class of prescription drugs — including semaglutide (Ozempic®, Wegovy®) and tirzepatide (Mounjaro®) — originally developed for type 2 diabetes and now widely prescribed for weight loss. GLP-1s have become a significant and fast-growing driver of pharmacy costs for self-funded and fully insured employers.
- **ICHRA (Individual Coverage HRA)** — An employer-funded account that reimburses employees for individually purchased health insurance premiums and eligible medical expenses. An alternative for employers who cannot or choose not to offer a group plan.
- **Level-funded plan** — A hybrid funding arrangement in which an employer makes fixed monthly payments covering expected claims, stop-loss insurance and administrative costs. If actual claims come in below the funded amount, the employer may receive a refund at year end.
- **Medical stop-loss captive** — A licensed insurance entity in which multiple employers — typically mid-sized organizations with similar risk profiles — pool risk, share in underwriting surplus, and gain greater control over claims data and plan management. Structured around self-funded health plans with stop-loss insurance layered in to protect individual members against catastrophic claims.
- **Network Provider (PPO/ACO)** — The healthcare delivery system associated with a self-funded or captive plan, providing a contracted provider network, negotiating reimbursement rates, and managing provider credentialing. PPO (Preferred Provider Organization) and ACO (Accountable Care Organization) are the most common network models.
- **Non-BUCA carrier** — A health plan carrier that operates outside the major national BUCA networks. Often used in level-funded and alternative funding arrangements to bypass traditional carrier overhead and administrative load.
- **PBM (Pharmacy Benefit Manager)** — The prescription drug program administrator in a self-funded or captive arrangement, responsible for managing the pharmacy network, processing prescription claims, negotiating drug pricing and rebates, and managing the formulary and specialty drug programs.
- **PEO (Professional Employer Organization)** — A co-employment arrangement in which a PEO becomes the employer of record for HR, payroll and benefits purposes, giving small to mid-sized employers access to large-group benefit purchasing power and HR infrastructure.
- **Reference-based pricing (RBP)** — A cost-containment strategy that reimburses healthcare providers at a defined reference point — typically a percentage of Medicare rates — rather than negotiated network rates. RBP bypasses the chargemaster entirely, anchoring reimbursement to Medicare fee schedules plus a defined percentage, typically delivering 20–40% savings on facility costs.

Glossary of Terms

- **Reinsurer / Stop-loss carrier** — The risk transfer partner in a self-funded or captive arrangement, responsible for underwriting the stop-loss insurance policy and paying catastrophic claims above the employer's specific deductible or the captive's aggregate threshold.
- **Self-funded plan** — A benefits funding arrangement in which an employer assumes direct financial responsibility for employee healthcare claims, paying claims as they occur rather than paying a fixed premium to a carrier.
- **Specific deductible** — The per-member, per-policy-period dollar threshold below which an employer in a self-funded or captive arrangement is directly responsible for paying claims. Claims above this threshold are funded by the captive layer or reinsurance, depending on the structure.
- **Specific stop-loss** — Also called individual stop-loss — a stop-loss insurance provision that caps an employer's liability for any single member's claims in a plan year. Once a member's claims exceed the specific deductible, the stop-loss carrier reimburses the excess.
- **Stop-loss insurance** — Insurance purchased by self-funded employers to protect against catastrophic or unexpectedly high claims. Comes in two forms: specific (per individual) and aggregate (total plan).
- **TPA (Third-Party Administrator)** — A company that administers health plan claims, eligibility and reporting on behalf of a self-funded employer without assuming insurance risk. In captive arrangements, the TPA also coordinates with the PBM, COBRA administrator, and provides data and reporting to the captive manager.
- **Underwriting surplus** — The surplus that remains when claims and expenses come in below the premiums or funds collected — also referred to as underwriting profit. In a captive or self-funded arrangement, this surplus is returned to the employer rather than retained by a carrier.

Common misconceptions

MYTH

"These strategies are only for large corporations."

REALITY

Group captives, level-funded plans and RBP are increasingly designed for employers with 50–1,500 employees. The middle market now has access to the same tools large corporations have used for decades.

MYTH

"Moving away from fully-insured means taking on unlimited risk."

REALITY

Most alternative structures include stop-loss protection that caps employer exposure. The risk is managed differently — and more transparently — not eliminated.

MYTH

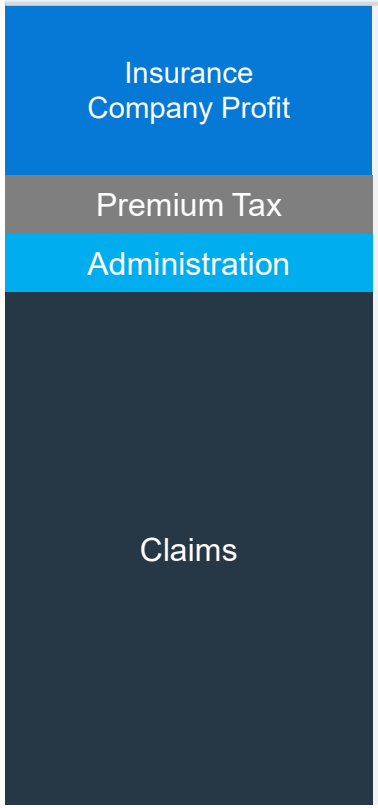
"If an advisor steers us away from a solution, they can't deliver it."

REALITY

A HUB advisor who says 'this isn't right for you' is demonstrating expertise and integrity — not a gap in capability. That honest counsel is the differentiator.

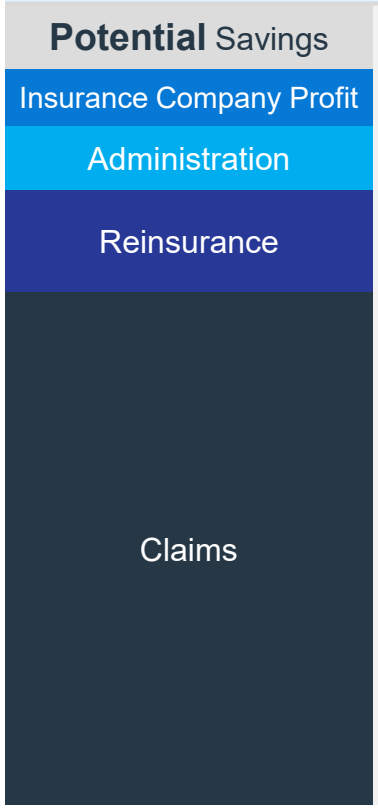
Cost Elements: Plan Funding Choices

Fully Insured Plan



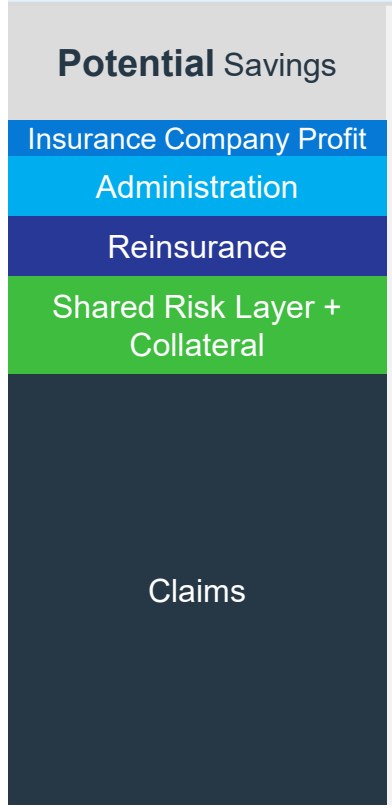
- ✓ Fixed premium
- ✓ Carrier profit
- ✓ No transparency
- ✓ State mandates
- ✓ No control

Self-Funded Alone



- ✓ Pay claims direct
- ✓ Keep savings
- ✓ Full transparency
- ✓ More volatility
- ✓ Medium control

Self-Funded Medical Stop-Loss Captive



- ✓ Shared risk pool
- ✓ Keep savings
- ✓ Transparency
- ✓ Less volatility
- ✓ High control

Less — **Control, Pricing, Creativity, Information, Flexible Analysis** — More

Two types of stop-loss protection – and how they work together

Specific (individual) stop-loss

- **What it is:** Caps the plan's liability for any *single member's* claims in a plan year

  Example: ISL = $100,000 → Member A runs up $750,000 in claims → Plan pays $100,000, captive layer covers $300,000, reinsurer covers $350,000
- Typical thresholds: $50,000–$1,000,000 depending on group size

Aggregate stop-loss

- **What it is:** Caps the plan's *total* liability across all members in a plan year

  Example: Per-member deductible = $50,000, Captive layer = $150,000, Aggregate attachment point = $1,500,000 → Once cumulative claims reach $1,500,000, captive and stop-loss activate → Claims reaching $1,800,000 trigger the aggregate deductible layer
- Limits worst-case annual exposure
- Attachment point typically set at 110–125% of expected claims

From Claims Data to Better Decisions

Claims Data

Medical claims

Pharmacy claims

Utilization

Diagnoses

Provider patterns

Clinical Intelligence

Emerging risk

Care gaps

Cost drivers

Risk Trajectory

Stop-loss exposure

Strategic Decisions

Stop-Loss Strategy

Carrier engagement

Renewal protection

Plan Design

Coverage structure

Benefit alignment

Funding Strategy

Self-fund readiness

Timing and structure

The same claims data. A different lens. A more informed decision.

Example of self-funded feasibility analysis

Historical Fully-Insured Performance				
Year	**2023-2024**	**2024-2025**	**2025-2026**	**Total** [3]
Premium	**$1,541,102**	**$1,680,223**	**$1,397,576**	**$4,618,902**
Net Claims	**$859,232**	**$724,921**	**$867,749**	**$2,451,901**
Claims	$1,011,698	$724,921	$909,182	$2,645,801
Claims Over Assumed $75,000 Spec	-$152,466	$0	-$41,434	-$193,900
Premium Less Net Claims [1]	**$681,870**	**$955,303**	**$529,827**	**$2,167,000**
Estimated SF Administration	$78,021	$86,661	$78,730	$243,412
Self-Funded Stop-Loss Price Estimate [2]	$259,137	$345,401	$376,549	$981,087
Estimated Rx Rebates	($60,702)	($43,495)	($54,551)	($158,748)
Total SF Fixed Costs [4]	**$276,456**	**$388,567**	**$400,728**	**$1,065,751**
Total SF Estimated Cost	**$1,135,688**	**$1,113,488**	**$1,268,477**	**$3,517,653**
Savings/(Cost) of Self-Funded Total	**$405,414**	**$566,736**	**$129,099**	**$1,101,249**
Likelihood of Self-Funded Being More Favorable [5]	**High**	**Very High**	**Medium**	**High**

1) This line represents the portion of cost (premium) that was not allocated to claims for members; thus, it was what the group paid for administration, pooling, and related costs.
2) Stop-loss premiums used from Claros Analytics and assumed to have increased **20% retrospectively**.
3) Totals for administration/stop-loss calculated using the weighted average of enrolment from each period multiplied by the estimated rates. The current plan year only has **11 months of claims**, resulting in a lower portion of the weights.
4) Total SF Fixed Costs include **Administration Fees, ISL Premiums, ASL Premiums and assumed Rx rebates equal to 20% of Rx claims** for each year.
5) To date, whether this group would be better off self-funded is likely tied to its willingness to engage in cost-containment programs available in self-funded arrangements.

Funding Models, Protection and Control

No Control	Minimal Control	Some Control	High Control	Ultimate Control
Fully Insured	Self-Funded	Self-Funded	Self-Funded	Self-Funded
Carrier Administration	Carrier ASO	Carrier Owned TPA	Independent TPA	Independent TPA
Built-In Stop Loss	Carrier Stop Loss	Carved Out Stop Loss	Carved Out Stop Loss	Carved Out Stop Loss
Carrier PBM	Carrier PBM	Carved Out PBM	Carved Out PBM	Carved Out PBM
Carrier Utilization Management	Carrier Utilization Management	Carrier Utilization Management	Carved Out Utilization Management	Carved Out Utilization Management
Carrier Network	Carrier Network	Carrier Network	Carrier Network	Alternative Payment Providers