The Funding Spectrum

Five ways to fund employee insurance coverage.

A guide for employers evaluating their options |
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The Choice You Arrived With Is Not the Only One

The choice most people arrive at for their health insurance is a light switch: fully insured on one side, self-funded on the other. For many, self-funding can feel like too big of a jump from the plan they are on today. So they stay where they are, absorb the renewal, shift some cost to employees and do it again next year.

What most people in that position have never been shown is how much exists between those two poles. The options across the spectrum were built specifically to give companies more than a binary choice, each one suited to a different situation, a different cash flow position, a different appetite for risk and visibility into what is actually driving cost. We are highlighting five of them here.

67%	of covered workers nationally are already in self-funded or alternative arrangements. Among companies with 200 or more employees, that figure jumps to 80%.[1]

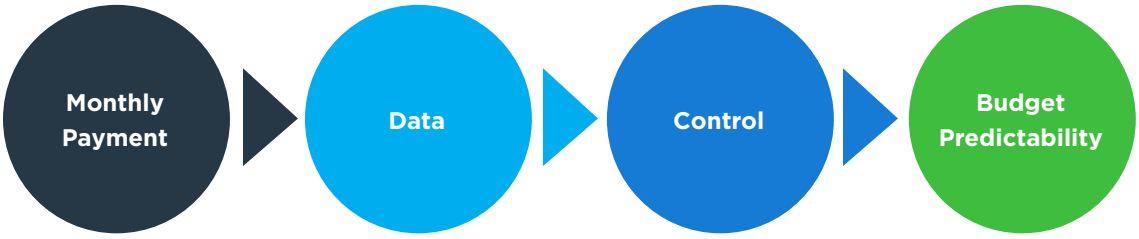
The employers who have moved from fully insured are not taking on unknown exposure. They found a position on the spectrum that fit their situation. Most of them were surprised by how navigable it was.

The five structures that follow are not a ranking. They are a map. Each one is built for a different situation, a different set of priorities, a different answer to the question of how much visibility and control you want over your benefits spend. Most companies find that one of these five structures fits their situation better than they expected. A few confirm that where they are is exactly right. Either outcome is a good one.

How to Use This Guide

The spectrum runs from fully insured on one end to true self-funded on the other. As you move across it, four things change: what you pay each month, what data you receive, what control you have over your plan and what your monthly budget predictability looks like.

Moving further along the spectrum does not mean moving into the unknown. It means shifting from a structure where the carrier holds those variables to one where you hold more of them. Each position is a deliberate tradeoff. The right one depends on your workforce stability, your cash flow, your claims history and how much visibility you want into what is driving your cost.



1 KFF, "2025 Employer Health Benefits Survey," October 22, 2025.

Fully insured

The starting point for many. The right answer for some

What you pay each month	A fixed premium set prospectively by the carrier, guaranteed for the plan year. Your number does not change during the plan year.
What data you get	Limited. With fewer than 250 employees, you typically receive aggregated, high-level summary data. Availability varies by carrier. You cannot use it to manage cost in real time. For larger groups, data is still carrier-controlled, aggregated and retrospective in most arrangements
What control you have	Minimal. Plan design must conform to the carrier's options. The carrier manages cost and holds claims' fiduciary responsibility.
Budget predictability	High. Your monthly number does not change during the plan year.

Right for you:

Your workforce is not predictable, you need every administrative complexity handled by a carrier or your situation genuinely makes a multi-year funding commitment inadvisable right now. Fully insured is not a fallback. For some situations, it is the best option.

Not right for you:

You are staying there by default, without having examined whether a better-fit position exists. If your concern is a steady monthly number, that is worth a conversation before ruling anything out. Other positions on the spectrum could still be viable options worth exploring.

What fully insured employers often cannot see: the portion of your premium that goes to carrier administration (8% to 12%), carrier profit (1% to 4%), state premium taxes (2 to 3%) and risk and contingency loads (1% to 3%).[2] For a company paying $3 million in annual premiums, that is approximately $420,000 per year that does not pay a single claim.[3]

[2] National Association of Insurance Commissioners, "U.S. Health Insurance Industry, 2024 Annual Results," accessed June 18, 2026.
[3] KFF, "2025 Employer Health Benefits Survey," October 22, 2025.

Level funded

The most accessible first step

What you pay each month	A fixed monthly installment covering your expected claims plus stop-loss protection. Your number does not change during the plan year. You know what you will pay before the month starts.
What data you get	Monthly claims reporting with descriptive analytics and large claims detail. You can see what is driving your cost in a way your current arrangement likely does not allow.
What control you have	You are technically in a self-funded contract, which means the structure belongs to your plan, not the carrier. More plan design flexibility than fully insured. ERISA governance.
Budget predictability	High. If your claims come in under projections at year end, the surplus comes back to you, not the carrier's bottom line. If claims exceed projections, that deficit may be written off or carried over until termination with the carrier.

Right for you:

You want a fixed monthly number and claims visibility without a structural leap. This is the position that feels most like fully insured, with one meaningful difference: You can see your data. That data is the starting point for every cost management decision that follows.

Not right for you:

Your workforce or financial profile makes any departure from carrier-guaranteed rates inadvisable right now. If you are not sure, that is exactly what a conversation with an advisor is for.

"Level funding feels a lot like fully insured. Your monthly number is fixed, the structure is familiar, but you are technically in a self-funded contract, which means you get data. That data is the starting point for everything that comes next. It is the step that goes from not knowing anything about your claims to being able to see them."

Medical stop-loss captive

Budget predictability with participation in good claims years

What you pay each month	A fixed monthly contribution to the captive pool. You know your number before the month starts. Your contribution does not vary based on what your employees actually used that month.
What data you get	Full claims data ownership. You see every claim, every cost driver, every trend line. The data belongs to your plan.
What control you have	You join a pool of employers with similar profiles and a shared commitment to cost management. The pool purchases stop-loss reinsurance that caps catastrophic exposure for the group. When the pool performs well, the surplus returns as dividends or rate credits. If claims exceed expectations, future contribution increases may be shared across the pool.
Budget predictability	High floor, with upside participation. Your monthly contribution is fixed. When the group's claims come in under projections, that outperformance comes back to the employers in the pool, not to a carrier.

Right for you:

You want the budget certainty of a fixed monthly contribution, full claims data ownership and the ability to participate financially in years when your employees are healthy. This is not a quick renewal-cycle decision. Companies that have moved into captive structures typically spend more than one renewal cycle reviewing their claims data and financial profile before joining a pool.

Not right for you:

You have not yet built a claims history or your workforce stability and financial profile make a multi-year strategic commitment inadvisable right now. For most companies, level-funded is the right first move before a captive — it builds the claims history and operational familiarity that makes a captive conversation realistic down the road.

Reference-based pricing

A different cost layer, available at multiple positions on the spectrum

Reference-based pricing is not a standalone funding structure. It is a cost layer that can be applied alongside level-funded, captive or true administrative services only (ASO) arrangements.

What it changes	Providers are paid based on a Medicare-derived benchmark rather than carrier-negotiated rates. The difference between those two numbers, at the provider and procedure level, is often significant and is not visible inside a fully insured arrangement.
What it requires	A minimum viable size of typically $1.5 million to $2 million in annual claims. A dual-option structure is available at open enrollment. This is not a passive structural change. It requires active employee communication, particularly in the early months.

Right for you:

You are already in an alternative funding arrangement and want to address provider cost directly. Also relevant if you have multi-state operations or locations where network access creates friction for employees.

Not right for you:

You are not yet in an alternative funding arrangement or your employee population would not be well served by a non-network model without careful implementation and communication planning.

A self-funded plan

Maximum control, for the right situation

What you pay each month	Your monthly amount reflects your employees' actual claims. It can vary based on what your employees actually used. This is not a fixed monthly number in the way the other positions are.
What data you get	Complete. You own the data. Member-level, deidentified, monthly. You can carve out programs, build direct provider contracting, manage your formulary and make network decisions independently.
What control you have	Maximum. Plan design is yours. Vendor selection is yours. You choose your own administrator, your own network and your own pharmacy benefit structure. You are not inside a carrier's model.
Budget predictability	Your payment reflects what your employees actually used. The amount can vary month to month.

Right for you:

You have stable claims history, cash flow that can absorb month-to-month variability and a benefits team with the bandwidth to manage additional administrative responsibility. If you are exploring alternative funding for the first time, this is not where you should start.

Not right for you:

You need a fixed monthly number, your workforce is not predictable or your team does not have the capacity for the administrative complexity this structure carries.

Where Most Companies Start and How They Move

The most common first move for fully insured employers exploring alternatives is level-funding coverage. It solves the budget certainty question, introduces claims visibility that your current structure likely does not provide and does not require a structural leap to get there.

The captive conversation typically comes after you have built a claims history. For some companies that happens in a level-funded year. For others it takes longer, and that is a normal timeline.

Four questions that help locate where you belong

1. How predictable is your workforce?

Stable headcount, long-tenured employees and consistent claims history make you a stronger candidate for alternative funding than a workforce with extremely high turnover or significant year-to-year volatility.

2. What does your claims history show?

Loss ratios under 70% to 75% over three years indicate the carrier is retaining money that your employees' good health produced.

3. What is your cash-flow position?

Level-funded and captive structures give you a fixed monthly number. True ASO does not. Your position on the spectrum should match what your cash flow can actually absorb.

4. What does your benefits team look like?

The administrative difference between fully insured and level-funded is modest. Between fully insured and true ASO it is not. Be honest about what your team can manage before choosing a position.

Ready to get started?

Contact a HUB Advisor at hubinternational.com