AMWINS®
BENEFITS

A Better Benefits Experience

2026 State of the Market

Introduction

Affordability continues to define the employee health benefits landscape, influencing decisions for employers, brokers and carriers alike. While higher rates are oftentimes attributed solely to the insurance industry, the reality is far more complex. Cost pressures are building across the entire healthcare value chain. Provider reimbursements, pharmaceutical pricing, utilization trends, economic factors, legislation and regulation, site-of-care variances, technology and health innovation — and a litany of other influential dynamics — all paint a small portion of the larger picture.

This report aims to unpack the most timely, relevant topics identified by our experts and provide you with actionable insights.

A Message from Our President

The recent rebrand to Amwins Benefits is more than a name change — it reflects a fundamental evolution in how we serve our clients and the market. By bringing our operating companies together under strategically aligned verticals, we've built a platform capable of reaching every corner of the employee benefits space, and this year's State of the Market report reflects that ambition.

New this year, we're delivering data and expertise from across the benefits landscape to provide a more robust look at the industry through the lens of our five solution verticals.

We think that breadth of perspective matters now more than ever. Rising costs continue to pressure employers and plan sponsors. PBMs are facing heightened regulatory scrutiny that will reshape how pharmacy benefits are structured and delivered — brokers are navigating an increasingly competitive environment where differentiation and expertise are everything.

Our goal is to deliver the insights and resources needed to lead with confidence in a market that is anything but static.

Riva Dumeny, President
Amwins Benefits

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Economic & Regulatory Conditions

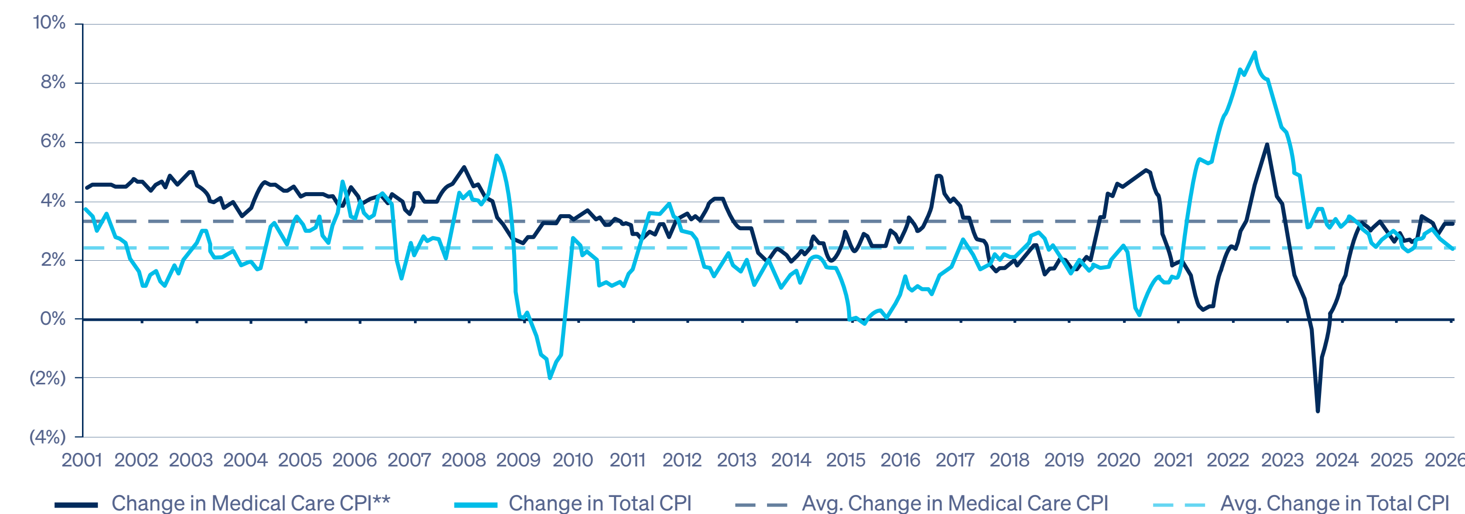
Healthcare Expenses, Medical Inflation and Utilization

Healthcare expenditures are a significant, fast-growing cost center for many organizations, and emergent economic and market pressures are bringing heightened attention to the financial impacts of offering group health coverage.

Medical inflation stalled post-COVID relative to overall inflation and, in 2024, began rising again in a more typical fashion. However, inflationary trends and a myriad of healthcare industry-specific factors are driving the material market changes — and severe cost shifts — within a relatively short period.

Today, health expenditures represent about 18% of total economic spending in the United States. This statistic has consistently increased over the past few decades and the trend is expected to continue. In 2000, health spending comprised about 13% of total GDP* and is projected to represent about 20% in 2033. In other words, $1 out of every $5 spent will be attributed to healthcare.

Medical Inflation vs. Overall Inflation



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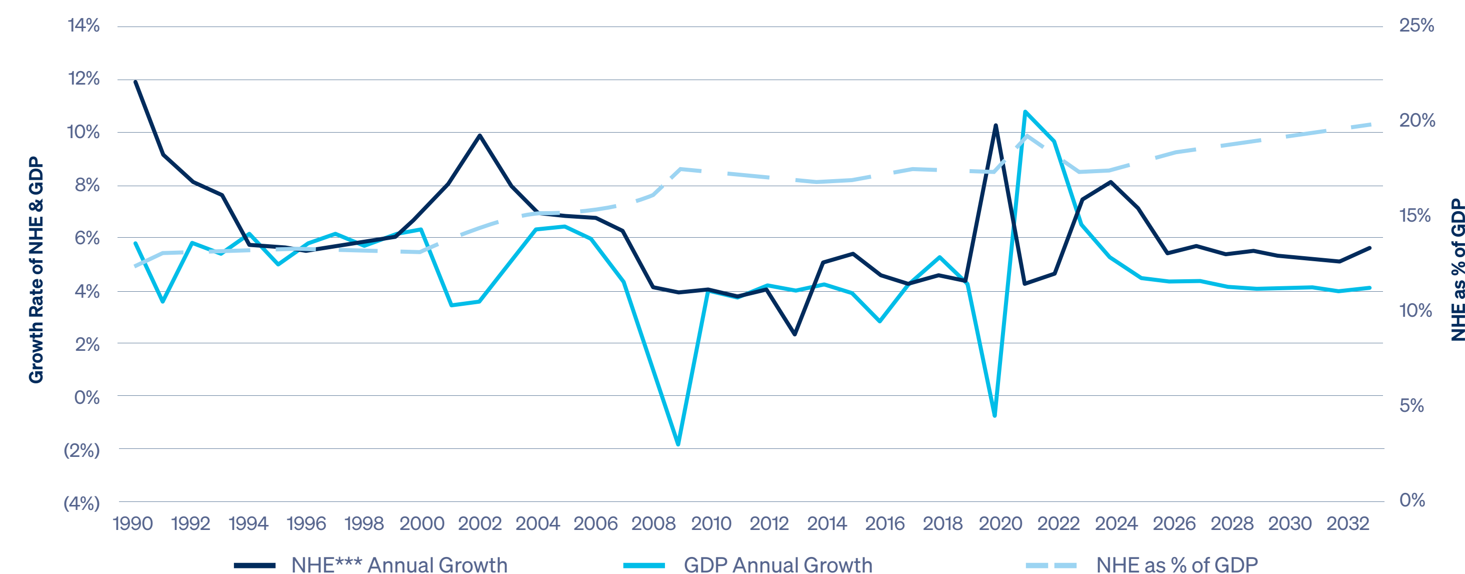


** Gross Domestic Product (GDP) is the total monetary value of all final goods and services produced within a country's borders in a specific time period.*
*** Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for goods and services.*
**** National Health Expenditure (NHE) is the official, annual estimate of total U.S. healthcare spending published by the Centers for Medicare & Medicaid Services (CMS).*

Consistent health expenditure and GDP growth trends are naturally driving increases in renewal rates for fully insured and self-funded plans. Private health insurance spending rose to $1.645T in 2024 (an 8.8% growth rate) and represented 32.6% of the national healthcare spend.

Over the past few years, focused efforts to shift care to outpatient facilities, ambulatory surgery centers and in-home care likely kept post-COVID hospital utilization spikes at bay. According to recent National Health Expenditure (NHE) data, a combined 53% of the country's $5.3T health spending was attributed to hospitals (31%) and physicians and clinics (21%).

However, patient care is up at hospitals, and an American Hospital Association™ analysis highlights a 5% increase in case mix. Hospital teams are addressing more complex and severe conditions — along with a 30% increase in survival likelihood and a significant spike (95%) in preventive breast and colorectal cancer screenings.

With a return to more typical utilization levels and a firmer grasp on specific profitability goals and shortfalls, health system and network contract negotiations are becoming increasingly challenging. In recent years, health systems across the country invested significant resources into Health Services and Technology (HST) to become more efficient and improve patient care. The large-scale outflow of resources into HST, paired with healthcare workforce shortages, elevated labor costs and overall inflationary cost trends, is naturally translating into higher service costs for patients and payers. Providers are raising base costs to maintain existing discount structures or reducing the discounts offered to insurers. No matter the tactic, increasing costs are problematic for all parties involved in negotiations.

Prescription drug spending by commercial plans continues to spike, fueled by more widespread use of GLP-1s, specialty therapies, infusions and biologics. As a benchmark, in 2014 the estimated annual pharmacy spend per commercial plan enrollee was $694; in 2024, it was $1,626. During the same 10-year period, prescription volume rose by 28%, and the average prescription costs jumped by 84%. According to the Business Group on Health 2025 Employer Health Care Strategy Survey, 27% of employers' 2023 healthcare spend was attributed to pharmacy, up from 21% two years prior. Escalating prescription drug utilization and widespread price variations for specific medications and infusions (based on site-of-care administration) are increasingly burdensome for plans.

Benefits Cost and Rate Trends

Inflation, healthcare workforce shortages, emerging high-cost specialty therapies, prescription drug use and costs, and more frequent $1M+ claims are heavily influencing the commercial market. Eye-opening renewal quotes are expected to continue.

While employee healthcare coverage can be viewed as an investment in individual workers and their families, as well as a tool to attract talent, benefits are a significant expense for an organization, no matter its size. According to the Kaiser Family Foundation (KFF) 2025 Employer Health Benefits Survey,* premiums rose by 6% from 2024 to 2025, reaching an annual average of $26,993 of employer contribution for family coverage. Employees contribute approximately $6,850 (about 25% of total) toward coverage. Each of these have increased by about 25% since 2020.

** KFF is an independent source for health policy research, polling and news. KFF's annual Employer Health Benefits Survey gathers self-reported data from private and non-federal public employers with ten or more workers. The 2025 survey included 1,862 interviews.*

Average family premiums have grown aggressively over the past decade, and benefits costs have risen at a 5% compound annual growth rate (CAGR) since 2019. In 2015, the average family premium hovered around $17,680, with employers contributing to about 72%. Employers continue to bear the brunt of the increases, and today, contribute about 75% of the $26,993 average family premium expense. Between 2015 and 2025, employer and employee contributions increased by 59% and 38%, respectively.

Median medical plan cost trend increases are certainly accelerating. With a predicted 6% to 9% increase in 2026 — and some experts noting a heavier lean toward the higher end of the range — this year could mark the highest annual renewal projections in more than a decade. Carriers are often applying medical cost trends of 10% to 12% in formula renewals, with pricing models that bake in buffers to offset volatility and high-cost claims.

Publicly-filed final rate changes for the small group market landed near the 11% range, and premiums for individuals shopping the ACA Marketplace rose by an estimated 26% for 2026. The sharp spike in cost, paired with the end-of-year expiration of enhanced premium tax credits (subsidies) in December 2025, posed significant financial challenges for enrollees. Cost pressures have also led to carrier exits and reduced competition in the small group, fully-insured market.

▸ In Action
Brokers will typically define a group's size relative to their specific agency size and client base. However, this report defers to ACA definitions in which "small group" is classified as one to 50 full-time equivalent (FTE) employees, except in CA, NY and VT, where small group includes up to 100 FTEs.

This year, prescription drugs are driving the highest estimated increases for plans, at 11%. While specialty drugs (for serious conditions such as cancer or hemophilia) account for less than 2% of prescriptions, they drive nearly 50% of total drug spend. Drug pricing, practices, programs and policies are a hot topic of conversation across the board.

Overall, rising healthcare costs further underscore the importance of a full benefits package to better manage employees' out-of-pocket exposure. Employees are relying on their employers to offer solutions to offset — or fill — coverage gaps, and brokers have an opportunity to bolster the value of a plan by strategically integrating relevant ancillary benefits.

Payer Mix Trends and Enrollment Shifts

The growing Medicare and Medicaid population will further exacerbate the pressure in the commercial market. Flat or reduced government reimbursements and profitability shortfalls experienced by health systems and carriers must be offset through higher reimbursement rates from commercial payers. Overall demographic trends, underwriting strategies, economic conditions, legislation and policy, public health status and consumer expectations all play a part in this dynamic period.

The U.S. Census Bureau estimates that by 2030, one in every five individuals in the country — including all baby boomers — will have reached retirement age of 65+. This demographic turning point, known as the "silver tsunami," will drive a massive surge in Medicare enrollment and intensify pressure on Medicare financing and provider availability over the next few years.

At the same time, this shift will amplify reliance on (and intensify policy debates around) government-created incentives that bolster large hospital systems through disproportionate share payments and 340B programs.

Enrollment in Medicare Advantage (MA) — the private plan alternative to traditional Medicare — has increased steadily over the past two decades. Today, 34M individuals — more than half of eligible Medicare beneficiaries — have selected a Medicare Advantage plan. MA enrollment is highly concentrated among plans owned by a handful of parent organizations, with UnitedHealth Group and Humana accounting for nearly half (46%) of all enrollees nationwide. Some experts predict MA plans will collect $76B in payments in 2026 — a 14% higher expense than covering the same beneficiaries within traditional Medicare.

Medicaid and Affordable Care Act (ACA) plans are likely to face significant challenges related to rising rates, disenrollment and expiration of enhanced premium subsidies. Across the 2026 Marketplace Open Enrollment Period, 23M consumers signed up for individual market health insurance coverage through federal and state marketplaces, a drop from the 24.2M consumers who selected a Marketplace plan in 2025. Some experts predict these segments will experience a 9M to 10M member loss in 2027 — with some of those individuals transitioning into employer-sponsored plans — and that both markets will move toward stabilization and recovery in 2028 and 2029. The continued migration of lower-risk ACA members to alternative funding arrangements will further erode the stability of the individual market risk pool. This trend will likely elevate already-challenging renewal increases into the 2027 cycle.

Rising Healthcare Costs: Policy, Legislation and Impact

The cost of healthcare — including health insurance and out-of-pocket expenses — now tops the list of the American public's economic anxieties. Two-thirds of the participating population (66%) in a 2026 KFF Health Tracking Poll are more concerned about affordable healthcare (including out-of-pocket costs, office visits, and prescription drugs) for themselves and their family than the rising costs of utilities, food, housing and gas. A majority (56%) of survey respondents expect healthcare costs to become even less affordable in the coming year.

This widespread public concern is echoed in the Trump Administration's targeted efforts to reduce prescription drug costs and enact policies centered on consumer awareness, patient choice and transparency.

Under the current Administration, priorities, initiatives and actions relevant to the healthcare and insurance sectors include:

- Addressing the transparency and rising costs of healthcare
- Prescription drug costs: securing Most Favored Nation (MFN) pricing and negotiating Medicare drug costs
- Evolving economic and trade policies
- Spending reduction to Medicaid and Affordable Care Act (ACA) exchanges
- Expiration of enhanced premium tax credits (subsidies)

The federal budget reconciliation law — H.R. 1, the One Big Beautiful Bill Act (OBBBA) — signed in July 2025, includes provisions to address federal spending on Medicaid and ACA exchanges.

Due to this legislation, the Congressional Budget Office expects a $1T reduction in spending on Medicaid and the ACA marketplaces. An additional 4.2M individuals will feel the impacts of the expired tax credit enhancements, which previously lowered the premiums by more than $700 annually for eligible enrollees.

In Action

In January 2026, CMS announced its list of 15 high-cost, single-source prescription drugs to be negotiated under Medicare Parts B and D. Any agreed-upon maximum fair prices (MFPs) for this third cycle of negotiations are scheduled to take effect on January 1, 2028. According to CMS, "the selected drugs accounted for $27B in Total Expenditures under Medicare Part B and Part D" between November 2024 and October 2025. Negotiated MFPs are expected to reduce pharmacy spend, PBM revenues and, naturally, commercial plan rebates.

TrumpRx

In line with heightened attention paid to prescription drug costs and markups, the current Administration has focused on TrumpRx since the latter part of 2025. TrumpRx is not an insurance plan or formal coverage structure. The initiative (not a policy) aims to secure most-favored-nation (MFN) pricing for certain brand-name medications, promote direct-to-consumer (DTC) cash pricing and increase competitive pressure. The TrumpRx program also leverages economic policy to persuade pharmaceutical companies to invest in domestic manufacturing and offer MFN pricing on specific drugs. As of March, over 80 prescription medications were listed on the TrumpRx website. The included drugs treat a range of common conditions, such as asthma, arthritis, infertility and diabetes.

It is important to note that any purchases made outside of a member's pharmacy benefit structures do not count toward deductibles or out-of-pocket maximums. While some insured individuals may bypass their plan if the manufacturer's cash price is lower than their cost with insurance, many argue that TrumpRx will primarily benefit uninsured and underinsured individuals. Emerging details about this initiative are available on trumprx.gov.

Scan or click the QR code to read a bulleted summary of Required PBM Transparency Disclosures compiled by the Self-Insurance Institute of America (SIIA).

Pharmacy Benefit Manager (PBM) Pricing Transparency

In February 2026, Congress enacted legislation to expand PBM transparency obligations and provide group health plans with significantly more insight into PBM compensation and pricing practices. These changes build on existing federal transparency initiatives and are intended to address long-standing rebate structures, spread pricing arrangements and potential conflicts of interest that have contributed to higher prescription drug costs.

As part of this effort, Congress clarified the scope of ERISA's § 408(b)(2)(B) compensation disclosure rules by eliminating prior references to specific categories such as "brokerage services" or "consulting," and instead applying the disclosure requirements to any service provider that furnishes services falling within the statute's enumerated list. This clarification is designed to ensure that PBMs are subject to fiduciary-level compensation disclosure obligations based on the services they perform, rather than how those services are labeled.

The legislation also reinforces the expectation that prescription drug rebates and other price concessions received by PBMs be fully transparent to plans, and, in certain cases, passed through to the plan rather than retained by the PBM. Industry guidance and recent updates from SIIA describe these requirements as encompassing detailed disclosures regarding PBM payment practices, including rebates, price concessions, spread pricing, gross versus net drug costs and whether covered drugs are dispensed through PBM-owned retail, mail-order or specialty pharmacies.

In Action

In February 2026, the Federal Trade Commission (FTC) secured a landmark settlement with Express Scripts. This decision will fundamentally alter Express Scripts' PBM business model and could reshape how drug pricing works across the industry. Among other directives, the FTC order:

- prohibits Express Scripts from favoring higher-list-price drugs
- requires that patient out-of-pocket costs be based on net prices rather than list prices
- increases transparency for plan sponsors
- mandates that point-of-sale rebates be passed directly to patients
- expands access to DTC pricing channels (such as TrumpRx)
- shifts incentives away from rebate-driven formularies

In parallel with congressional transparency efforts, the FTC's recent decision emphasizes a demand for true net cost pricing rather than acceptance of opaque list prices and intricate rebate programs. Plan sponsors still have some flexibility to negotiate alternative arrangements, and the long-term competitive effects will unfold as implementation proceeds.

Strong bipartisan support for addressing excessive concentration and conflicts of interest in the healthcare industry is evident through intentional, across-the-aisle collaboration. In 2024, two Democrats and two Republicans, including Senators Elizabeth Warren (D-Mass.) and Josh Hawley (R-Mo.), introduced the Patients Before Monopolies (PBM) Act, intending to "untangle healthcare middlemen's dual ownership of pharmacies, limiting expensive conflicts of interest."

In February 2026, Senators Warren and Hawley teamed once again to jointly introduce the Break Up Big Medicine Act and "address rampant consolidation in the healthcare industry that drives up prices, squashes competition and fuels corporate greed." Bipartisan support suggests that addressing such structural issues may gain traction. If enacted, the Break Up Big Medicine Act will mandate health insurers and PBMs to divest their pharmacy businesses within one year.

The pharmacy benefits landscape will be significantly dismantled and reshaped if PBM transparency and anti-competitive legislation achieve the intended outcomes.

Fiduciary Duties and Legal Responsibilities

High-stakes lawsuits and increased scrutiny around fiduciary duties, transparency, data, disclosures, fees and PBMs are hot topics this year. Brokers, service providers and other individuals who exercise discretion or fiduciary authority in implementing and managing employer-sponsored plans must understand how plan funds are spent and why.

Regulatory policy changes and clarifications around data and disclosure of fees and costs highlight the importance of fiduciary responsibilities and non-compliance risks.

ERISA* requires responsible oversight of private sector employer-sponsored health plans and mandates a prudent, well-documented decision-making process. It is important to note that ERISA is not intended to be punitive; rather, it focuses on the conduct and process followed by fiduciaries. However, ERISA-focused lawsuits have sparked greater awareness about fiduciary duties over the past few years and a handful of cases have moved through the court system. It is yet to be seen exactly how recently emerging lawsuits will play out.

State-Specific Legislation

ERISA generally preempts state laws that relate to ERISA-covered employee benefit plans. However, the uptick of state laws related to service providers, PBMs and leave policies poses big challenges for employers managing multi-state employees and operations. Keeping up with the nuances, opportunities and restrictions on a state-by-state basis is a notable challenge, especially for small groups lacking dedicated Human Resources (HR) personnel or professional support.

▸ In Action

Employer-sponsored health plans and Third Party Administrators (TPAs) are not bound to the same fiduciary responsibilities. Differences in Administrative Services Agreements (ASAs) — where timelines may be loosely defined as “reasonable” rather than a specific number of days — open the door for some TPAs to withhold reporting or medical rebates, including warranties. TPAs may also refuse to integrate with vendors offering higher-value services, even if it is in the employees’ best interest.

**Employee Retirement Income Security Act of 1974*

Market Trends & Insights

Healthcare benefits remain a competitive tool for employee recruitment and retention. As such, benefits are evolving from a physical health-only focus into total rewards packages with a whole-person view. Overall, the benefits market is moving toward bundled and tech-enabled service delivery. Employers expect more integrated, intuitive experiences to include benefit administration, decision-making support, wellness solutions and ancillary lines. They desire simplified enrollment, actionable analytics and measurable ROI. We see a push for tech-driven claims processing and proactive employee engagement solutions.

A Tightening Benefits Market

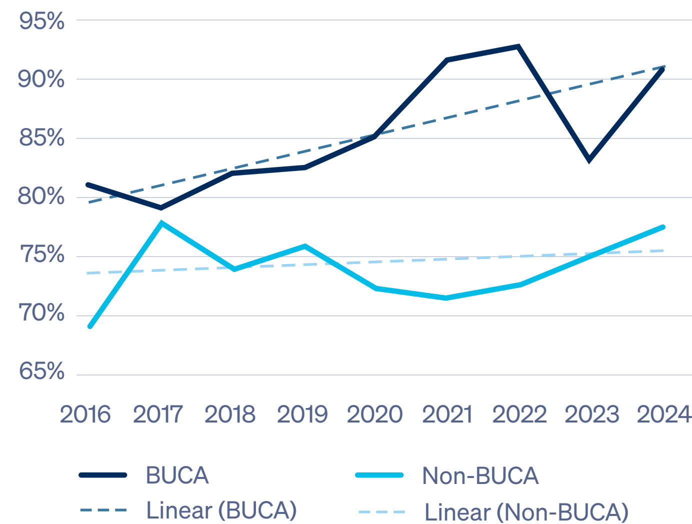
The high-disruption period many experts had predicted certainly unfolded in real-time during this most recent renewal cycle. Hard negotiations, difficult decisions and rate shopping have been especially challenging for carriers, brokers and employers. Most experts anticipate similar challenges heading into the 2027 cycle.

Scan or click the QR code to read it now. Amwins Self-Funded's Market Insights Report is a concise resource for brokers to educate and prepare groups for what is likely to be another arduous year ahead in the group health market.

As a result of the general rise in healthcare costs, claims that traditionally fell below $100,000 now easily top the $250,000 mark and are doing so with increasing frequency. One stop-loss carrier experienced about a 60% spike in $1M+ claims per year (per million covered employees) between 2021 and 2024, including nine $5M+ claims in 2023. Another reports a 1,250+% increase in claims exceeding the specific deductible by $2M+ since 2013. No matter the data point, high-dollar claims are absolutely more frequent and severe than ever — and this trend will continue for the foreseeable future.

This cost trend naturally translates into more high-dollar claims reaching stop-loss thresholds and pressuring carrier loss ratios. According to NAIC's 2024 Accident and Health Policy Experience Report, stop-loss carrier loss ratios increased from 80.4% to 85.8% from 2023 to 2024, the highest mark in at least the past eight years. An analysis based on five of Amwins Self-Funded's largest stop-loss carrier partners (shown on the next page) tells the same story. Increased carrier loss ratio pressure may result in additional market exits.

Stop-Loss Carrier Loss Ratios Over Time*



The majority of volume (between 90% and 95%) is associated with stop-loss carriers with $100M+ in premium. BUCA carriers (accounting for between 55% and 60% of total market stop-loss premium) typically outpace loss ratios compared to other stop-loss industry participants, although an exception is noted in 2017. In 2024, loss ratios for BUCA carriers and non-BUCA carriers were reported at 90.5% and 77.5%, respectively.

Carriers have become increasingly selective with risk pools and are deploying tighter underwriting across the board. The predicted rate increases signaled by carriers and experts over the past few years came to fruition during the 2026 cycle. In light of the startling renewal packages, brokers are increasingly open to alternative strategies to reduce rates and overall costs. Extended sales cycles (with more inquiries, "rate shopping" and quoting activity) paired with greater scrutiny and flat close rates have been especially challenging. This trend is very likely to continue into the 2027 cycle and beyond.

The small group fully insured market should expect continued volatility. Rising premiums, reduced product differentiation, shrinking carrier capacity and limited underwriting flexibility will push more small employers to explore alternative funding arrangements.

Smaller plans are accepting greater levels of risk as they aim to balance costs and coverage, signaling a broader tolerance for increased financial exposure. Industry experts caution against chasing price when making critical risk-related decisions, especially into 2027. Many plan sponsors lack the financial savvy to fully understand potential impacts and should rely heavily on brokers prepared to educate and guide.

Data compiled from publicly available sources and aggregated by Amwins' actuaries.

High-Cost Claims Conditions

Widely referenced industry sources showcase specific high-cost claim conditions and stop-loss trends each year. Frequency rankings differ by carrier (based on total claims), but the following conditions historically round out the top ten: Malignant Neoplasm, Leukemia, Lymphoma, Multiple Myeloma, Cardiovascular, Orthopedics/Musculoskeletal, Hemophilia, Genitourinary System (Urinary or Renal), Sepsis and Newborn/Infant Care.

Based on 2024 high-cost claimant data from several of our largest carrier partners, the most frequent high-cost condition categories include:

	Claim Frequency Per 10K Employees	Average First $ Claim Size	Amwins Self-Funded Claim Rank by Frequency*
Malignant Neoplasms	15.7	$360,000	1
Diseases of the Circulatory System; Cardiovascular	4.7	$310,000	2
Diseases of the Digestive System	2.5	$270,000	3
Endocrine and Metabolic Diseases	2.4	$340,000	7
Injury and Poisoning	2.3	$420,000	8
Respiratory	2.2	$270,000	10
Diseases of the Musculoskeletal System	2.1	$240,000	4
Diseases of the Nervous System	2.0	$310,000	5
Perinatal	1.7	$490,000	13
Infectious Disease	1.6	$380,000	11

Malignant neoplasms are the most frequent and severe condition associated with high-dollar and $1M+ claims, accounting for nearly 35% of Amwins Self-Funded's $1M+ claims during the 2025 calendar year. While not as frequent, newborn and perinatal claims can be especially severe and are the second most common driver of $1M+ claims.

Rank is based on stop-loss claims paid during the 2025 calendar year and the most frequent primary diagnosis of large claimants.

One in every 500 babies are born at 24 weeks and classified as "extremely preterm." With medical advances and active care, extremely premature babies must remain in a hospital for at least four months (and some up to a year) to have a solid chance at survival. The reasons for a preterm birth are not always clear, making newborn claims especially tough to predict.

In Action
Tech-focused early interventions can prevent dollar-one costs from snowballing. Pre-claim reviews, payment integrity partners and audits can reduce waste and mitigate additional spending for self-funded groups. Beyond mitigating a spiraling stop-loss claim, these strategies can drive consistent, incremental savings and address artificially inflated charges or outlier provisions.

Emerging Healthcare Opportunities: Medical Innovation, Rx Pipeline and Novel Therapies

From clinical trials, navigating the U.S. Food and Drug Administration (FDA) approval pipeline, deploying go-to-market strategies and monitoring real-time patient outcomes, the cost-benefit analysis of medical innovation is complex and costly.

Government incentives (such as grants, tax credits and exclusivity protections) encourage manufacturers to invest in novel gene and cell therapy research. Accelerated FDA approval pathways can expedite the traditionally lengthy and expensive process.

Current federal leadership has advocated for making the U.S. a "hub of biotechnology innovation." Bringing new gene and cell therapies to market, particularly for rare and life-threatening genetic conditions in young people, is a priority.

Gene, Cell and CAR-T Therapies

Exciting advances in healthcare innovation (including novel biologics and life-saving therapies) require employers to prudently balance access, risk and cost along with unknown "what ifs." To date, the FDA has approved nearly 40 gene, cell and CAR-T therapies, with the majority treating rare or very rare diseases. A handful of FDA approved CAR-T therapies have received FDA approval for patients to access the therapy as an earlier treatment option or "line of treatment" this year, contributing to a widening patient pool.

There are 264 therapies in development, with 40%-50% being considered for oncology. Oncology and rare diseases are the top areas of gene therapy development, and between seven and 10 treatments are likely to earn approval before the end of 2026. Experts believe the majority of approvals this year will focus heavily on oncology.

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Costs for currently approved therapeutic drugs are staggering, with 14 landing at $2M+ and one reaching $4.25M per dose. Administration fees range from tens of thousands to upwards of $1M, with facility charges, administrative costs and pharmacy markup contributing to the extreme variances.

The pool of patients eligible for gene and cell treatments will naturally grow as therapies are approved to address more common disease states, such as diabetes, Parkinson's, Alzheimer's, knee osteoarthritis, prostate cancer, diabetic peripheral neuropathy, cardiovascular diseases, multiple sclerosis and neovascular (wet) age-related macular degeneration — the most common cause of severe vision loss across the globe. One source expects 85+ new gene therapy approvals by 2032 with an estimated 10-year list price spend of $35B to $40B.

For self-funded plans, cost-containment programs tailored to gene and cell therapy claims can help mitigate financial risk for plan sponsors and stop-loss carriers. Early diagnosis and detection of rare conditions will spur faster intervention with already-approved therapies. All 50 states include spinal muscular atrophy (SMA) in their newborn screening panels, and Zolgensma — with a $2.5M price tag — is the only gene therapy to treat SMA at birth. (The sooner a patient receives a treatment correlates to a greater probability of a more successful outcome.) Zolgensma is the most desirable option for newly diagnosed SMA patients. However, Itvisma is a newly approved gene therapy option available for individuals above the age of two.

In Action
In Amwins Self-Funded's book of business, one in 100,000 (or 40 people) are expected to experience a gene or cell therapy claim that falls under Amwins Gene Therapy Solutions program. In 2025, this same population pool experienced 37 gene and cell claims totaling $32.1M. Data indicates a 24% increase in risk over a recent one-year period.

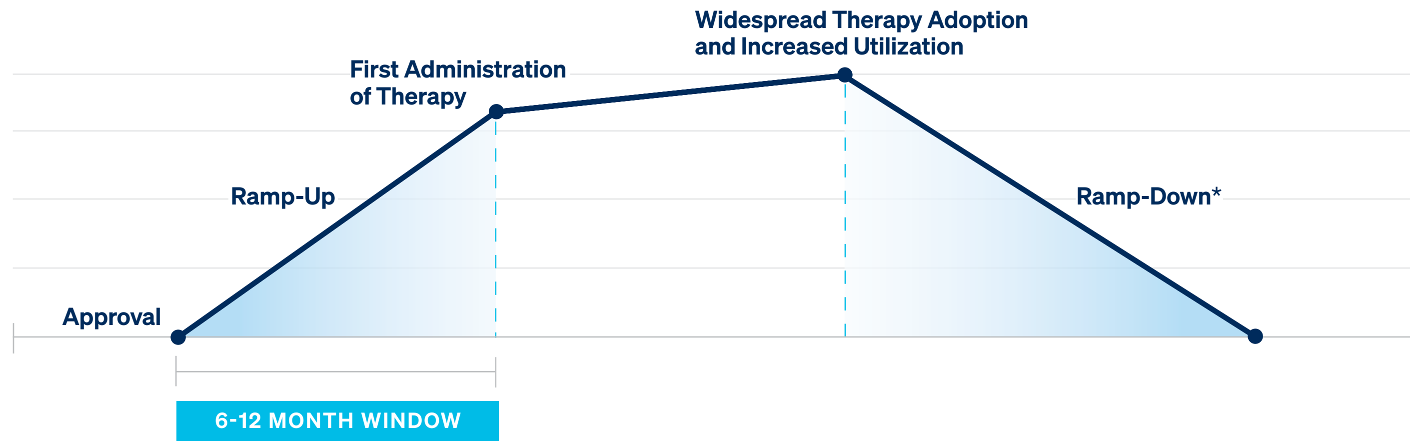
High-cost cell and gene therapy claims, particularly in the absence of protective cost-containment programs, will strain the entire market and accelerate hardening conditions across the board. Stop-loss carriers have experienced a handful of significant gene and cell claims across their blocks of business. However, most report that the lower-than-anticipated frequency has kept losses within their anticipated range. While the prevalence and incidence of gene and cell therapy claims have been lower than expected, the risk should not be underestimated or ignored.

New biologics and therapies follow a typical pattern, influenced by research and development, FDA approval, market introduction and patient adoption. Ramp-up refers to the period after a new therapy is approved but before patients begin receiving treatment. This phase accounts for:

- manufacturing
- building a pipeline of eligible patients
- distributing the drug to approved hospitals
- preparing the health system to administer the therapy

A delayed six- to twelve-month window between approval and the first administration of a cell or gene therapy is typical. In the ramp-down phase:

- utilization declines (as most eligible patients who had been awaiting the therapy have had the opportunity to receive it)
- new competitors and therapies may enter the market
- emergent clinical data will further influence use and labeling



In Action
Historically, CAR-T therapy has been used to treat certain types of blood cancers (leukemia, lymphoma and myeloma). Recent innovation in the CAR-T space indicates the potential to treat solid tumors, which account for over 91% of all adult cancer cases worldwide. According to a report by the American Society of Gene & Cell Therapy, CAR-T therapies account for 32% of the total gene and cell therapy pipeline and target cancer treatment in 97% of cases.

Infusions, Injections, Biosimilars, Specialty and Generic Drugs

Along with life-changing innovation in gene, cell and CAR-T therapies, the expanding pipeline of biosimilar and specialty medications also presents incredible promise for patients alongside significant costs. Not long ago, a plan could anticipate a 10% to 15% prescription drug spend. In the most extreme cases, pharmacy costs can consume 30% or more of plan resources.

In the "ramp-down" phase, utilization decreases and typically becomes more predictable and consistent.

Infusions are often critical to a care plan and sometimes the only available treatment for specific conditions. They are also a notable driver of higher stop-loss premiums and financially burdensome for patients and plans. The site of care — whether in-home, at an outpatient clinic or in a hospital setting — drastically shifts the cost to administer the same drug from manageable to almost crushing. In instances where a small percentage of a covered population drives the majority of a plan's costs, personalized care, guidance, and clinical oversight are both paramount and possible. Self-funded plans are highly encouraged to consider cost-containment solutions for infusions.

As of March 2026, the FDA has approved 83 biosimilars (generic biologics), and dozens of biosimilars are in active development and awaiting approval. Compared to brand-name versions, biosimilar alternatives and traditional generics can reduce costs by up to 80% and 95%, respectively. However, bringing biosimilars and generics to market takes years. Most branded drugs are protected from duplication by a competitor under a 20-year patent, and additional protection (granted by the FDA) provides exclusive marketing rights for a specific period after a drug's approval.

In Action
Rising prescription drug costs are not driven solely by brand name or specialty drugs, and it is no longer sound to evaluate a plan's pharmacy spend by category alone. Generic drugs account for over 90% of retail prescriptions but are not always managed as actively as specialty drugs. Additionally, generics are not always "low cost," especially when they fall into specialty categories. And, while generic drug pricing has generally remained stable, higher overall prescription drug utilization and concentrated pockets of supply chain volatility reinforce broader pharmacy cost concerns for groups.

Site-of-care changes and formulary design can greatly impact a group's greatest net savings. Employers should consider strategies to educate workers about site-of-care options and the varying novel therapies, biosimilars and generic drugs as appropriate.

In Action
Hospitals serve a critical purpose in communities, and non-urgent, routine or chronic condition management need not occur in an acute care setting. Administering infusions at an outpatient clinic, ambulatory care center or in-home — rather than within a hospital — will deliver extreme cost savings for health plans and increasingly so if patients require multiple rounds of treatment. To illustrate how theory translates to dollars, one Amwins Self-Funded group saved $28,006 per treatment (and $485,438 per policy period) when infusions were delivered at an outpatient center rather than in a hospital. Plans can educate covered members about various sites of care, rather than accepting a hospital setting as the only option.

GLP-1 Injectables and Pills

GLP-1 weight management drugs are directly contributing to aggregate per member per month (PMPM) cost increases. And while GLP-1 claims are certainly not severe or catastrophic, a sharp increase in frequency and prevalence has led some employers to add 2% or more to their budgets for GLP-1 drugs alone. Novo Nordisk's Wegovy earned FDA approval in December 2025 and came to market as "the first and only GLP-1 weight-loss medication pill." A daily GLP-1 pill from Eli Lilly was approved in April 2026.

Whenever a new drug or method of administration enters the market, expanded access and convenience typically drive increased utilization and adoption.

Additionally, while the list price for GLP-1 pills and injectables is the same at this time, the self-pay cost for the oral medication is approximately $50 per month lower. Some experts anticipate more meaningful cost savings in the coming months for individuals who choose GLP-1 pills.

In Action

Aggressive marketing campaigns and digital strategies will keep GLP-1s top-of-mind for consumers for the near future. Novo Nordisk spent nearly $487M to promote Wegovy and Ozempic in the first nine months of 2025. Eli Lilly invested about $131M to advertise its obesity treatment Zepbound in the same period (versus $2M in 2024) and spent $83M to promote Mounjaro, a diabetes medicine.

According to AON's "Workforce-Focused Analysis on GLP-1s: Phase Two Findings," following an initial increase in spending, GLP-1 users in the weight loss and diabetes cohorts experienced slower medical cost growth (medical and non-GLP-1 pharmacy spend) compared to non-GLP-1 users. Shedding additional weight with GLP-1s may alleviate long-term, chronic stress on hips, knees and hearts or even prevent high-dollar chronic health conditions down the line, though that assumption remains largely speculative. However, GLP-1 use may spur an uptick in elective or cosmetic surgeries that were previously not possible (or relevant) before significant weight loss. AON's study highlights notable positive impacts for women using GLP-1s, including a lower incidence rate for ovarian and breast cancer compared to matched female non-users.

Regional Health Systems and Provider Network Agreements

Some experts have noted a shift toward regional networks as compared to national systems, particularly within self-funded plans. National networks rely heavily on PPO discounts. However, combining a strong TPA with a regional network allows for embedded, high-touch case management and additional point solutions to help control costs.

We continue to see widespread network and provider contract negotiation challenges. This trend has emerged in pockets over the past few years and is likely to continue. Most agreements span two- to five-year cycles (with a three-year span being most common), and negotiations are increasingly strained. Hospitals are reevaluating their network agreements and arguing that deep discounts — such as 35% to 40% reductions for certain insurers — are no longer sustainable, especially given the shifting payer mix, high-dollar investments in health technology and the spiking utilization of high-cost specialty drugs. To protect profitability, providers must either raise base prices to maintain existing discount structures or aggressively reduce the discounts. Delayed or derailed negotiations impact brokers and employer groups sporadically. However, when negotiations do go awry — or fall apart completely — brokers, plan sponsors and covered members must work through significant disruption.

Carrier Entrants and Exits

The excess reinsurance market that supports the MGU segment is experiencing notable disruption. Three established carriers have exited the stop-loss market in the last few months, and perhaps more will follow. These developments have fueled market uncertainty and widespread speculation about the reasons behind the exits.

Predictions on how this movement will (or will not) impact the market are solely speculative at this point. While there does not yet appear to be a capacity shortage, growing frustration among market participants and workforce reductions are playing out in real time. Few carriers are speaking publicly about the shifts and time will tell if new players jump in.

The limited competition and concentration trend in the fully insured space has been noted in nearly every major region across the country. In many states, Blues plans remain dominant and demonstrate a continued focus on fully insured plans, while other carriers are focusing instead on business or captives — or removing themselves completely from the small group fully insured market.

Challenges in medical underwriting abound as "healthier risk" aims to transition to different structures and carriers are forced to navigate spiking health system costs. Limited competition in the small to mid-market space is a pressing concern, and according to KFF data, many states have a single dominant insurer.

In general, baseline expectations about benefits and workforce priorities are changing alongside the generational shift of the current workforce. By 2030, Millennials (b. 1981-1996) and Gen Z (b. 1997-2012) are projected to comprise nearly 75% of the workforce, and the majority of millennial employees prioritize and utilize mental health benefits. The increasing demand for fertility care, comprehensive women's health support, and caregiving benefits (for both children and aging parents) reflects broader demographic and societal changes influencing plan options and decisions.

In Action

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires plan coverage for mental health and substance use disorder treatments in parallel with medical and surgical services. Some experts estimate up to one in four adults in the U.S. have experienced any mental illness, including depression, anxiety, substance use disorder, Attention-Deficit/Hyperactivity Disorder (ADHD) and Post-Traumatic Stress Disorder (PTSD), and nearly 40% of all long-term disability claims are related to a mental or behavioral health condition. Mental and behavioral health claims escalated most dramatically during and post-COVID, and telehealth (virtual) therapy has been meaningful in expanding access to care.

Self-Funded
Market Overview

According to KFF's 2025 Employer Health Benefits Survey,* 67% of U.S. workers are enrolled in a self-funded plan. Of the employers covering 1,000 to 4,999 and 5,000+ workers, 82% and 87%, respectively, opt for a self-funding structure.

Unsurprisingly, most self-funded organizations are larger, but the percentage of self-funded groups with 10 to 199 workers rose slightly, from 23% in 2024 to 27% in 2025. Fifty-seven percent of groups employing 200 to 999 workers are self-funded, slightly less than the 61% reported in 2024.

At a high level, we are seeing a story of "haves" and "have-nots," with more moderate to poorly-performing groups receiving the rate cap increases at renewal or, in the most severe cases, being completely declined. In contrast, competition for the best risks with a profitable history and favorable outlook is fierce, yielding no change or even rates below current.

Many self-funded employers are no longer achieving the cost-savings expected from PPO networks. This trend has led to more scrutiny and clamoring for transparent claims data, discount calculation strategies, pricing and network value.

Employers are increasingly open to exploring steerage strategies, cost-containment solutions such as dialysis and infusion programs, network creativity and custom medical and prescription drug administration. Groups that accept the status quo will be further subject to market hardening.

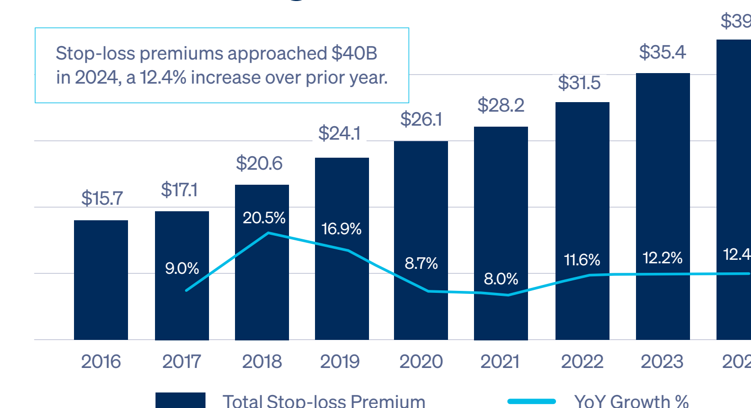
Groups are leaning heavily on brokers, TPAs and tech-forward vendor partners to deliver actionable insights, strategic guidance and plan structures that maintain robust coverage while controlling risk and rates. This dynamic is particularly complex as employers seek more flexible, cost-effective solutions (and act as fiduciaries) while TPAs are not upheld to the same fiduciary standard.

Additionally, when groups appear ready to implement new or recommended solutions, they often struggle when change may result in even minimal member disruption.

** KFF's 2025 Employer Health Benefits Survey includes self-reported information provided by private and non-federal public employers. Due to the complexity of the funding (and regulatory status) of these plans — and because employers often pay a monthly amount that resembles a premium — respondents may not fully understand whether their health plan is self-funded or insured. Confusion may also arise, as different plan administrators (generally insurers) use various labels to refer to these arrangements.*

Stop-Loss Market Growth** and Renewal Insights

Rising medical costs, carrier loss ratios and a shifting payer mix are shaping the growing stop-loss market. Stop-loss premium has increased by 250% since 2016, and the market is projected to reach $113.5B by 2034, growing at a 15% CAGR. Almost 93% of self-funded groups covering 200 to 4,999 lives and 66% covering 5,000 lives or more secured stop-loss insurance in 2025.



Stop-loss renewals have seen an uptick to leveraged trend levels or higher, along with underwriters seeking risk mitigation through lasers and other contractual changes. Rate cap increases and lasered options are more common than in years past, with underperforming risks seeing "max increase" renewals and hitting their rate cap at or around 50%.

Due to factors described earlier in this report, the stop-loss market is expected to continue to tighten over the next couple of years.

In Action
Self-funding, and in particular, level funding, continues to interest small to mid-market fully insured groups. Most inquiries are prompted by a reaction to unsustainable fully insured rate increases, but the allure of accessible data, transparent pricing and cost predictability achieved with self-funding is strong. Absent, incomplete or stale data available to fully insured groups often complicates the stop-loss quoting process and transition to self-funding, yet many still make the move.

Alternative Structures and Fully Insured Transition Opportunities

Brokers must navigate the pros, cons and various pathways when transitioning a fully insured group to alternative structures. Aligning expectations and identifying the right administrator, network, pharmacy vendor, key plan elements (such as integration capabilities and claims funding) and partners is important, but an employer's appetite for risk, group size and access to claims data will heavily influence plan-related options and decisions.

Employer Medical Stop-Loss Captives

Smaller and mid-sized employers often join group captive arrangements to leverage economies of scale, avoid volatility and mitigate risk. Captives have gained a reputation for outperforming traditional fully insured markets, but — because risk financing is distinct from risk mitigation — it is important to note that captives do not inherently create savings.

*** Data sourced from MyHealthGuide Newsletter by Ernie Clevenger and NAIC.*

Over the past 12 to 24 months, captives have reinforced their value as a long-term solution for financing catastrophic risk for self-funded health plans. The most successful group captive programs deploy consistent risk mitigation and cost-containment strategies at the plan level while managing oversight at the program level to ensure alignment across participating employers.

Effective cost-containment strategies remain closely tied to workforce demographics and member engagement. Additionally, a TPA's willingness to integrate with cost-containment vendors is critical for group health plans participating in a captive arrangement. Direct contracting, identifying the most effective network option and pharmacy benefit optimization continue to demonstrate measurable savings. Strategies outlined in more detail throughout this report, including member advocacy programs, steerage and payment integrity solutions, are especially impactful within a captive structure.

Looking ahead, employer medical stop-loss captives are expected to remain a viable long-term strategy for small to mid-size employers.

Level Funding

Level-funded health plans mimic the feel of a fully insured arrangement while realizing some of the benefits of self-funding. In this structure, employers can gain visibility into costs and utilization to better manage a long term strategy for employee health benefits.

Additional advantages include the ability to budget for and manage fixed monthly costs, access claims data and the potential to attain a refund on the surplus at year-end. Those same refunds are typically split with the carrier at a specified percentage and may be contingent on renewing with the incumbent.

The majority of large national level-funded carriers are offering more competitively quoted options to include anywhere from a 50% to 100% retention of surplus.

In Action

Increased scrutiny is emerging around level-funded and small group plans, particularly related to plan assets and levels of assumed risk. Regulators and enforcement generally focus on minimum aggregate corridors and specific deductibles, raising concerns about the "blurred lines" between level-funded and fully insured. The fundamental question surrounding the retention of plan surplus by parties other than the plan itself is whether the excess funds constitute employer-owned plan assets or, in the case of plans involving employee contributions, assets belonging to the plan's participants.

Level funding is gaining traction as fully insured groups explore savings opportunities and evaluate possible options for exiting the fully insured space. Level-funded plans are considered a type of self-funding, so they are not subject to state-mandated coverage laws and are generally exempt from state premium and ACA health insurance taxes. However, plan design options, vendor choice, reporting and pharmacy rebates are not as flexible as a traditional self-funded arrangement.

Small to Mid-Market Overview

According to the KFF 2025 Employer Health Benefits Survey, 54% of employers covering 10 to 49 workers and 59% covering 50+ employees offer group health benefits.

Across the 2026 renewal period, major carriers focused on the small group space cited significant losses, worsening risk pools and higher-than-expected utilization as the fully insured market attempted to weather unprecedented, above-average increases.

Rising premiums posed notable challenges for individuals and small groups. Nearly 90% of individual market enrollees received some form of subsidy, and, without the promise of enhanced subsidies (which expired in late 2025), healthier individuals may drop coverage.

It is too early to report how many employers will cut health insurance benefits due to overall unaffordability. Still, experts opine that nationwide rate spikes, coupled with the loss of expanded subsidies, will disproportionately affect small businesses and their employees.

In Action

Many perceive Individual Coverage Health Reimbursement Arrangement (ICHRA)* structures as simpler, more sustainable alternatives to ACA minimum value or gap plans. In some regions, ICHRAs were trending, but growth slowed due to climbing individual market costs. The cost challenges reiterated throughout this report have driven more frequent inquiries, especially in the last renewal cycle, among larger employers that typically classify benefits as a foundational component of total compensation. While ICHRA adoption is increasing among small employers, large employers are the fastest-growing segment. Several states are actively considering legislation to introduce ICHRA-related tax credits and incentives, signaling growing policy interest in encouraging small businesses to explore adoption of such plans. Whether curiosity, policy and interest will translate into meaningful ICHRA adoption trends is yet to be seen.

**An ICHRA is a formal, IRS-approved benefit allowing employers of any size to provide tax-free reimbursements for individuals who purchase health plans of their choosing. ICHRAs were created in 2019, with availability beginning in 2020.*

Fully Insured Small to Mid-Market Enrollment Trends

ACA enrollment losses are predominantly due to rising rates and product limitations. Also, as employers grow, they naturally transition out of the small group market and seek more flexible solutions and greater control. Fewer regional carrier options, rate volatility and network disruption are contributing to shifts in the small group segment.

Fully insured small group ACA rates are approved per state, and quotes are based solely on census data. As such, a fully insured employer can only control spend by reducing benefits, shifting costs to the employee or changing carriers.

In the fully insured market, carriers assume the entire risk and commonly handle administrative and compliance tasks, such as eligibility audits, claims management, and cost-containment solutions. However, small groups typically don't have access to claims data and cannot themselves directly address high-cost claims drivers, anticipate high-dollar health conditions, or steer care to cost-effective providers.

In Action

State-specific regulations influence, encourage or restrict certain plan options. For example, in NY, groups with up to 100 FTEs are prohibited from pursuing level-funded arrangements. In CA, smaller groups can move toward level funding but are required to also elect a sizable amount of stop-loss coverage and abide by minimum attachment points.

Although small groups are increasingly interested in level funding and self-funded structures that provide more access to member-level claims data, they typically lack the personnel, bandwidth or expertise to actively manage the required plan reporting and compliance. Brokers are imperative in helping the groups best suited for a fully insured plan see beyond the rates and understand the broader value. For some groups, fully insured plans can provide greater financial stability and protection as well as align more closely with the organization's overall benefits strategy.

PEO Market Overview

There are about 500+ Professional Employer Organizations (PEOs) in the $414B market, primarily serving small and mid-sized businesses and representing about 4.5M Worksite Employees (WSEs). As indicated in the chart on the following page, the five largest PEOs represent 51%* of the industry's WSEs, reflecting ongoing consolidation and scale advantages. PEO adoption is concentrated among small businesses with 20 to 499 employees, and groups with the highest penetration are among those with 50 to 99 employees. Membership in a PEO allows groups to join a larger, shared risk pool, enabling smaller employers to access high-quality health and ancillary benefits typically offered by large organizations.

PEOs are increasingly attractive compared to ACA small group plans, as they aggregate smaller employers into larger, professionally managed shared risk pools that help stabilize costs and reduce volatility. Reputable, well-structured PEOs with scale and negotiating power are built to sustain inflationary pressures, weather economic cycles and help small businesses effectively recruit and retain quality talent.

* NAPEO's 2023 PEO Industry Footprint reported a 39% WSE share for the five largest PEOs. However, Amwins' experts have derived more recent estimates based on the latest public filings, company disclosures and industry trends across 2025/26. The five largest PEOs include ADP TotalSource, Vensure, Paychex, Insperity and TriNet. Ongoing consolidation has increased top-tier share.

Just as small businesses vary broadly, no two PEOs are alike. They offer various structures, focus and benefits. Beyond health insurance, PEOs deliver operational and shared services support in strategic HR, compliance, workers' compensation (for eligible industries), and integrated technology to streamline and reduce administrative burden. Keeping up with ACA impacts and relevant federal and state-specific legislation — which sometimes move in different directions — is a significant stressor, and smaller businesses especially value the administrative and consultative support PEOs provide.

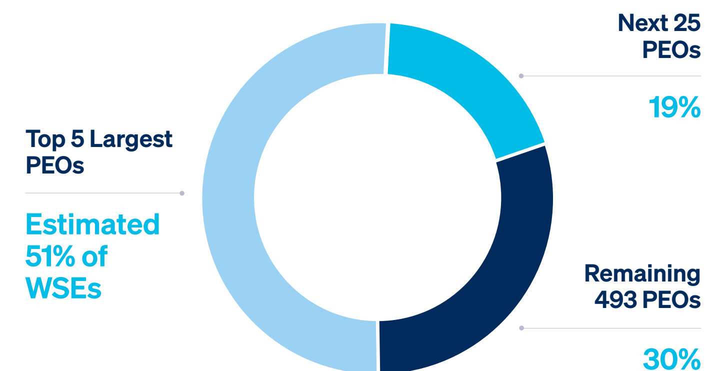
While PEO clients are concentrated in certain states, national PEOs operate in all 50 states. Many states require some form of PEO licensing, registration, bonding, reporting, or compliance filing. Advocacy organizations, such as the National Association of Professional Employer Organizations (NAPEO), strive to highlight the benefits of PEOs for the small business community without negatively impacting regional brokers.

Documented outcomes show that companies hiring a PEO grow twice as fast, have 12% lower employee turnover and are 50% less likely to go out of business — underscoring the PEO's role in powering resilience helping small companies compete more effectively in a competitive labor market where larger employers often have scale advantages.

In Action | PEO Market at a Glance

- Approximately half of PEO clients have between 10 and 49 employees, and 35% of PEO clients have fewer than 10 employees.
- Almost half of PEO clients are in these four industries: Professional/Scientific/Technical Services (19%), Construction (12%), Healthcare (9%) and Manufacturing (9%).
- Slightly more than half of PEO clients are located in these four states: FL (18%), CA (16%), NY (9%) and TX (8%).
- Healthcare inflation and pharmacy costs are still pressuring pools, and alternative models like PEOs continue to see a strong demand environment.
- Workers comp performance in key verticals (Construction and Manufacturing) remains a differentiator for PEOs with strong safety/return-to-work programs.
- Technology integration is enhancing service delivery and risk management.

Estimated PEO Industry WSE Distribution, 2025/26 — About 4.5M Worksite Employees



With PEO penetration still under 15% among firms with 500 or fewer employees and less than 3% of the total U.S. workforce, the industry offers substantial runway for growth amid persistent demand for benefits cost stability, multi-state compliance relief, workers' compensation management and talent retention.

Ancillary
Market Overview

The ancillary market is entering a new phase of transformation, expansion and consolidation, and employees expect greater choice and ability to customize benefits to meet their specific needs. However, managing ancillary benefits — not as a product but as a curated solution — has become increasingly time and labor-intensive.

In response, carriers are aiming to offer more than just competitive rates. Product functionality, carrier specific capabilities and service models are differentiators. Nearly all are focused on building deep, symbiotic partnerships with influential GAs (such as Amwins Ancillary) that can connect data, technology and service to streamline the overall experience. Groups are relying heavily on their selected broker to guide them through compliance heavy, complex processes with tech-centric integrations, niche industry expertise and unbiased advice. Carriers must provide value in their claims experience, technology capabilities and overall solution offering, and broker partners are expected to interpret nuance beyond "claims in, claims out."

Savvy brokers are seeking education and aligned strategic support in the ancillary space. Technology is no longer "nice to have" — clients and brokers expect an integrated experience. They are looking to carriers and GAs to find and provide solutions, and all parties in the ecosystem must be aligned with intuitive technology and tools.

Compliance-Heavy Statutory Disability and Leave Requirements

The statutory disability market will likely be reshaped by complex and disparate state-mandated leave requirements and employers' responsibility to comply with the patchwork of policies. While federal FMLA establishes a baseline, the patchwork of state-level leave laws has expanded materially. According to The Hartford's 2026 Future of Benefits Study, nearly 70% of employers report that state-level leave laws have added significant complexity to their work, while 60% worry about maintaining compliance. As HR professionals increasingly turn to their brokers for guidance, specialized GAs are stepping into that advisory role — providing the concentrated expertise and multi-state operational support brokers need to meet rising client expectations.

State-mandated Paid Family Medical Leave (PFML) programs have nearly tripled since 2020 — from five active state programs to 14 states and Washington D.C. as of May 2026. Five states and Puerto Rico require employers to provide Temporary Disability Insurance (TDI).

Eight states, mostly in the south and southeast regions of the country, deploy a voluntary system.

The combined statutory and private paid leave ecosystem — including state PFML/TDI programs, private disability and paid leave insurance, and employer-funded wage replacement — represents a multi-billion-dollar U.S. market, conservatively estimated in the mid-teens to low-twenties billions. Notably, U.S. workplace disability insurance new annualized premium alone reached $4.2B in 2024.* The market is projected to grow at a high-single-digit rate over the next several years, with advisory, administration, and placement-related revenues expanding at high-single- to low-double-digit rates. While the opportunity to scale is clear, leave management has become an increasingly complex — and often risk-laden — blind spot, particularly for large, multi-state employers

Along with state-mandated leave policies, multi-state employers are increasingly focused on standardizing internal, across-the-board employee leave policies. While not required by state or federal statute, this shift stems from a philosophical approach to a cohesive, company-wide employee experience, no matter a team member's zip code. Proactively exploring what is possible (from an internal policy standpoint) is certainly becoming a more widespread practice.

** LIMRA (Life Insurance Marketing and Research Association) is a global trade association providing research, consulting and professional development to insurance and financial services companies.*

In Action
Medical coverage may anchor broker conversations, but ancillary lines — particularly leave, statutory disability and absence management, along with worksite and supplemental benefits — now demand comparable strategic rigor. Escalating regulatory scrutiny, including recent ERISA class action activity, has pushed HR leaders to rely on brokers for compliance guidance, program design and disciplined carrier selection — needs that often exceed in-house capabilities. As the ancillary talent gap widens, brokers are intentionally partnering with specialized GAs like Amwins Ancillary for concentrated expertise, data-driven insights and deep carrier and administration relationships.

Leaning into a specialized, niche partner for strategic support is not about outsourcing knowledge. It is, however, centered on leveraging data-driven insights and facilitating relationships with reputable carriers and leave administration vendors to best serve clients.

Retiree Healthcare Market Overview

According to KFF, nearly 14.5M Medicare beneficiaries (approximately 24%) have employer-sponsored supplemental coverage. Employer-sponsored retiree health benefits are becoming increasingly rare as employers struggle to balance paternalism with increasing costs.

Retiree benefits are most often found in industries such as manufacturing, energy, public sector, higher education and unions. Some employers are contractually obligated to offer retiree benefits, while many elect this expanded coverage because it aligns with their broader philosophy on employee-employer responsibility.

From a utilization standpoint, the retiree population saw a pause in elective procedures — such as shoulder, knee and hip surgeries — during COVID, and the return to elevated hospital and outpatient usage has caused some rate turbulence. Covered retirees face many of the same challenges affecting other demographic groups, including rising prescription drug costs and overall increases in healthcare expenses. However, due to their age, adults aged 55 and older pose unique challenges for plans.

Employers offering retiree health benefits are engaged in a three-way tug of war as they attempt to balance their commitment to providing former employees with health coverage, navigate the rising cost of such coverage and manage the growing administrative burden associated with this offering.

Most employers are actively reexamining their current offerings.

In a carve-out approach that shifts retirees to a fully insured arrangement, a niche benefits partner handles all plan administration — including enrollee communication, onboarding, enrollment, education, billing and customer service — freeing the employer from day-to-day plan management. This structure alleviates much of the liability and administrative burden, prolonging the duration the employer can offer such coverage.

In Action

The retiree market is relatively small but full of opportunity. Through carve-out solutions or other creative strategies, groups can realize up to 30% or more in annual savings while drastically lowering liability. Savings are realized as a percentage of overall plan expenses, so employers can achieve meaningful cost reductions regardless of group size.

Carrier Insights

Rising healthcare costs affect fully insured and self-funded plans, but established carriers are positioned to weather the volatility of more frequent large claims.

Each carrier has a unique target appetite and risk philosophy — whether it be captives, reference-based pricing (RBP), small group, mid-market/large group, industry-centric or geographically-focused — but all are focused on retaining "healthier" groups and encouraging cost-containment strategies for self-funded plans.

The most recent stop-loss renewal cycle was atypically longer and later, with fewer early locks. Many groups that were offered early locks delayed making a buying decision and continued to shop and evaluate options. Decision lags during such a critical time also meant that carriers had access to months of additional claims data to better evaluate specific groups. Brokers and groups seeking a more compelling offer remained in the market, seeking additional and refreshed quotes later in the season. Overall, the stop-loss marketplace yielded less competitive pricing and a narrower range of compelling options. This trend is likely to continue into 2027.

Some groups faced significant stop-loss increases not seen in years. Others could not even secure quotes from certain carriers, with many of our experts noting the higher decline rates across this cycle. Groups with more favorable risk profiles, however, did find themselves in a less dire position. Some carriers were aggressively competing to retain "healthier" groups by offering flat or even declining rates this cycle. Staggering cost disparities tied directly to risk profiles were prevalent across the board.

▸ In Action

Focusing only on the stop-loss premium (a fixed cost) may lead plans to overlook broader financial risks or make short-sighted decisions without fully understanding the implications. Brokers are pivotal in educating employers about the implications of variable, fluctuating first-dollar claims costs and ensuring integration across stop-loss carriers, vendors and external service providers. Brokers can further support groups by proactively reviewing financial protections and Summary Plan Descriptions (SPDs), negotiating PBM contracts, requesting the opportunity to review sample contracts and data sets and appropriately funding their reserves.

The sharp spike in large, ongoing cancer claims across 2025 (especially in younger adults), infusions in hospital facilities and premature babies are top of mind for stop-loss carriers. While gene and cell therapy claims are also difficult to predict and remain on carriers' radars, such claims have not materially impacted loss ratios to date.

Step-down deductibles* are becoming more common, and payment integrity and claims review vendors are uncovering substantial savings for groups. Shared savings endorsements, while not as frequent, provide an opportunity for a stop-loss carrier to demonstrate a philosophy of partnership by allocating a percentage of savings back to the group.

** Step-down deductibles lower the employer's specific stop-loss deductible for a high-cost claim, and is usually offered in exchange for proactive cost-containment. For example, a step-down deductible provision could be triggered if a partner such as Emerging Therapy Solutions (ETS) is engaged for a gene therapy claim, which ultimately reduces the stop-loss carrier's liability.*

Despite the availability of AI, predictive tools and seasoned industry experts, accurately underwriting stop-loss for BUCA plans and ASO carriers remains difficult. However, BUCA business can be attractive, and some carriers believe in the model. In this situation, a general lack of visibility into claims data can result in a bump in the road at best or a $1M+ blind spot with serious cost implications. Unbundled administrators tend to be more flexible with transparent reporting and risk mitigation strategies.

Fully insured employers do not have access to detailed claims data. However, some carriers share high-level insights to help their insureds make different decisions and control costs within the overall risk pool. For example, certain members may be overutilizing urgent care instead of connecting with a primary care provider, choosing out-of-network doctors or overlooking virtual care (telehealth) as an effective option. Insights may help employers understand member behavior and, through education, possibly shift decisions to more cost-effective care options. While successful behavior change does not specifically impact individual fully insured employers, it can positively affect the greater risk pool.

Ancillary carriers are recalibrating across nearly every line. In dental and vision, carriers are leaning into network depth, member experience and digital-first enrollment to defend renewal pricing in an otherwise commoditized space, with several national carriers releasing refreshed PPO and DHMO products designed to compete more directly on out-of-pocket exposure rather than premium alone. In life and AD&D, underwriting has tightened modestly — particularly around guaranteed issue limits for mid-market groups — but capacity remains broad and rates remain stable.

Tension is most visible with STD and LTD, as carriers are watching mental health and musculoskeletal claim duration closely. Worksite, voluntary and supplemental lines continue to expand, with products increasingly bundled into broader financial wellness narratives.

A consequential shift is happening within statutory disability, leave, and absence management. Carriers are differentiating less on rate and more on administrative capability — specifically, their ability to manage multi-state PFML coordination, integrate with employer leave policies and deliver a defensible audit trail for compliance. Groups with operations across mandated, voluntary and non-mandated states are finding that carrier selection is now as much an operations decision as a pricing one, and the carriers winning this work are those investing in dedicated leave technology, claims advocacy and reporting.

For brokers, the practical implication is that ancillary carrier evaluation can no longer rely on a rate sheet alone. A disciplined vetting process — one that examines claims philosophy, technology integration, leave administration capabilities is increasingly the differentiator between a placement that holds and one that unwinds at the first complex claim. Across statutory, leave and worksite lines alike, rigor in marketing and placement is no longer a best practice — it is the foundation that protects the broker, the client and the placement itself.

Technology & AI

Artificial Intelligence (AI) is actively reshaping the insurance and healthcare ecosystems. From underwriting to claims to customer experience, AI is transforming how risks are evaluated, how brokers work and how insureds expect to be served. It influences when and why individuals seek care, the methods healthcare providers use to deliver such care and the way manufacturers supply prescription drugs.

Organizations that embrace AI will operate with more accuracy, speed and insight, reshaping the value they deliver. For brokers, this shift is not just technological; it is strategic. Beyond lower-risk administrative tasks, AI is now widely accepted as a supportive and supplementary tool for structuring unorganized data, analyzing complex datasets, identifying emerging conditions earlier and gaining direct insights into cost-containment strategies.

Amwins in-house data scientists are tackling complex, firm-wide opportunities, to accelerate technological development of our underwriting approach, reduce manual data entry processes, and optimize workflows.

AI is a tool for brokers and decision-makers, not a replacement for human judgment and industry expertise. The majority of industry professionals acknowledge the power of AI tools but recommend prioritizing the underwriting discipline, especially in more volatile and tougher-to-predict markets. AI has shown promise in streamlining RFP processes and workflows, particularly to manage the flurry of renewal activity each fall.

Fully insured carriers are leveraging AI to integrate with quote aggregators and gain visibility. They are actively promoting faster quote turnaround times, providing interactive comparison tools and offering more support for brokers as they educate groups and decision-makers.

Coding Strategies, Claims Processing Integrity Vendors and Legislation

Both the healthcare and insurance industries must balance AI-driven efficiency with appropriate controls and human oversight to mitigate fraud, waste and abuse. Market volatility has intensified the need for deep auditing and oversight in claims management. AI-enabled hospital coding and billing systems (particularly within DRG-based* reimbursement structures) are becoming more concerning. If unchecked, increased instances of AI-influenced coding intensity (or “aggressive upcoding”) will intensify upward pressure on overall cost trends.

Tech-based solutions are emerging to combat the issue, utilizing AI-enabled pushback, automated appeals and repeated re-submission requests. However, the exacerbated back-and-forth pattern is creating administrative friction, slowing claims processing and payments and increasing scrutiny from all sides. Delayed claims adjudication can also affect stop-loss reimbursement timing, particularly for policies that accumulate claims on a paid basis rather than incurred.

** Diagnosis-Related Group (DRG) is a patient classification system used by Medicare and insurers to standardize hospital reimbursement based on diagnosis, procedures and severity rather than only length of stay.*

Individual states have proposed and adopted specific AI laws and frameworks, but a December 2025 executive order seeks to update "...existing Federal regulatory frameworks to remove barriers to and encourage adoption of AI applications across sectors" and "...ensure that there is a minimally burdensome national standard — not 50 discordant State ones."

In Action

Technology is central to healthcare investment strategy and, particularly AI and automation tools, are perceived as strategic and viable drivers of revenue and growth. Investors are prioritizing healthcare software, tools and platforms to reduce administrative burden, ensure compliance, streamline claims processing and mitigate reimbursement uncertainty.

Advanced analytics allow stakeholders and new partners to segment and interpret data, recognize patterns and streamline decision-making with heightened speed and accuracy. These advanced analytics can help organizations make data-driven decisions, anticipate market shifts.

Emerging vendor partners and software companies are using AI and population health tools to track utilization patterns, identify early indicators of chronic conditions, highlight potential gene and cell therapy claims, optimize the member experience and steer care to value-based pathways. However, the effectiveness of any solution depends on access to comprehensive, clean and usable claims data. Without it, opportunities to meaningfully lower costs and improve outcomes remain limited.

Small Group Quoting

AI and risk data census underwriting in the small group market is gaining popularity. Front-runners in the AI-quoting space are significantly improving turnaround times and close ratios, and brokers are growing more comfortable using AI to drive efficiencies. In some markets, third-party vendors and carriers are providing medically-underwritten level-funded quotes in one day as compared to weeks. Some can provide that same information almost instantaneously.

Expectations are shifting, competitive pressures are rising and employees are seeking to access care in real time. As carriers continue to deliver a faster, more accurate quoting experience, groups are anticipating a similar expedited, streamlined implementation experience. However, small groups are often operating without seasoned Human Resources professionals or a Chief Financial Officer, so decision-makers are increasingly reliant on the expertise of a consultative broker partner.

Benchmarking Data

Brokers can use the information in this section to benchmark and compare similarly situated groups and guide employers through a variety of plan structures and options. However, contact your Amwins representative to identify the most appropriate strategies to balance risk, cost and protection and receive group-specific guidance.

Self-Funded Market Insights

65+
Carrier Markets

300+
Broker Relationships

3M
Lives Covered

40.9K
Spec Claims Reimbursed
(2025 calendar year)

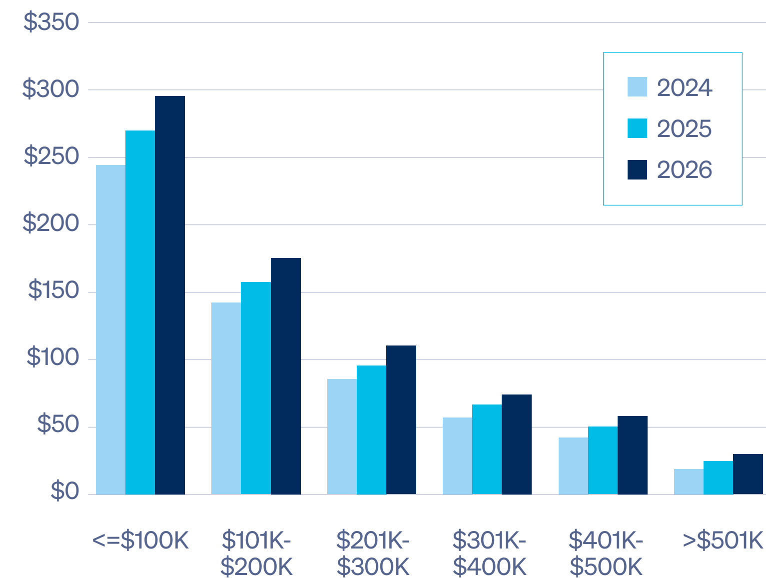
3,900+
Employer Groups

$2.8B+
in Stop-Loss Premium

#1
Annual Premium Placements

The following data from the Amwins Self-Funded book of business encompasses groups of all sizes and structures across the entirety of the U.S. Amwins Self-Funded's independent nature and depth and breadth of reputable partners — direct writers, BUCAs, niche MGUs and Amwins-owned proprietary markets — allow for a broad and unbiased view of industry trends and corresponding impacts on employer groups.

Stop-Loss Premium PEPM by Specific Deductible



Stop-Loss Premium Breakdown by Specific Deductible Range

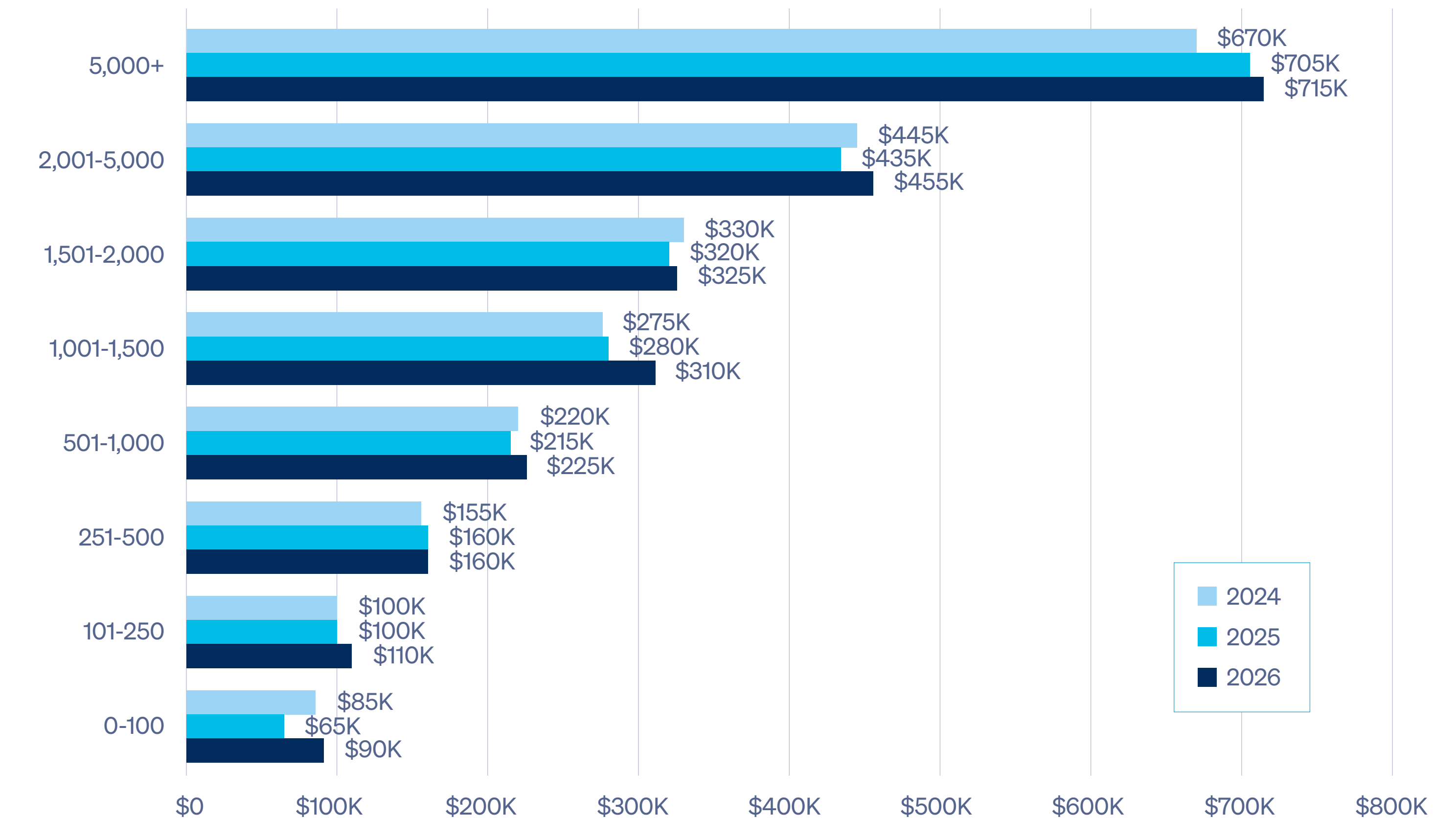
Specific Stop-Loss Deductible Range	2024	2025	2026	Annualized Trend
<= $100K	$244	$271	$298	10.5%
$101K to $200K	$141	$156	$176	11.8%
$201K to $300K	$83	$97	$113	16.5%
$301K to $400K	$56	$64	$71	12.3%
$401K to $500K	$43	$51	$57	14.9%
>$501K	$20	$25	$28	17.5%
Total	**$89**	**$100**	**$113**	**12.5%**

Key Takeaway

The PEPM premium trends between deductible buckets are largely consistent across the board, ranging from 10.5% to 17.5% and averaging to 12.5% across the book.

State of the Market 2026 | Benchmarking Data

Average Specific Deductible by Group Size: 3-Year Look Back



Key Takeaway

The average specific deductible by group size continues to see some fluctuation year over year, with an overall trend for modest growth.

Groups Electing Aggregating Specific (Agg Spec) Deductible and Corresponding Premium Decrease

	2025	2026
% Elected Aggregating Specific Deductible	27.5%	25.9%
% Premium Decrease	14.2%	14.1%

Key Takeaway

Overall, similar to last year, a consistent number of groups elected an aggregating specific deductible. The prevalence of aggregating specific deductibles is consistent across all levels, indicating it is a risk and cost mitigation solution used by groups regardless of size or specific deductible. Given the increase in overall premium, the premium offset from the aggregating specific deductible has remained relatively stable.

Top 10 Industries with Stop-Loss Coverage

Rank	Industry	% of Groups	Group Size Range*	Median Spec	Median Premium PEPM
1	Manufacturing	18%	60 to 1,100	$145,000	$200
2	Health Care and Social Assistance	14%	90 to 1,600	$150,000	$160
3	Professional, Scientific, and Technical Services	8%	70 to 1,200	$125,000	$210
4	Wholesale Trade	8%	70 to 1,400	$150,000	$170
5	Public Administration	7%	130 to 1,800	$150,000	$170
6	Construction	6%	70 to 1,400	$150,000	$200
7	Finance and Insurance	6%	110 to 3,100	$185,000	$150
8	Educational Services	6%	90 to 3,000	$165,000	$190
9	Other Services (except Public Administration)	5%	90 to 1,900	$175,000	$180
10	Retail Trade	5%	70 to 1,100	$125,000	$180

Key Takeaway
Across the board, Amwins Self-Funded partners with groups of all sizes, from just under 100 lives to several thousand. Of the top 10 industries in which Amwins Self-Funded places stop-loss, manufacturing claims the top spot — almost 20% of all groups. The finance and insurance industries tend to have the largest groups — selecting higher deductibles and slightly lower premiums.

Groups (by Size) Purchasing Aggregate Coverage by Year

Group (EE) Size	2024	2025	2026
0-100	85%	89%	84%
100-250	87%	86%	86%
250-500	78%	76%	77%
500-1000	66%	65%	62%
1000-1500	44%	46%	45%
1500-2000	46%	36%	35%
2000-5000	18%	23%	23%
5000+	7%	7%	5%

Key Takeaway
Claims predictability naturally increases as the number of employees in a group increases, so larger groups are more willing to forgo aggregate coverage. Consistent with recent years, most groups with fewer than 1,000 employees elect aggregate coverage. While catastrophic claims risk is an increasing concern even for large groups, very large groups are not purchasing aggregate coverage unless legally obligated to do so. In the Amwins Self-Funded book of business, large groups of 5,000+ employees include state-based programs and school districts.

In Action | The Complex Interplay of Rx Rebates, Agg Hits and Stop-Loss Recouping

Due to the infrequency of aggregate hits, the interconnectivity between rebates, aggregate hits and stop-loss is not widely understood. However, as prescription drug costs rise, the financial impacts of pharmacy rebates are becoming increasingly significant. In the event of an aggregate hit, stop-loss carriers often require prescription drug rebate data for that policy year. (Due to reporting lags, carriers may need to estimate the full rebate impact.) The rebate amount is then deducted from the total aggregate reimbursement, regardless of whether the plan sponsor is the direct recipient of the rebate(s). Even if the administrator retains the rebates to offset administrative costs, the final aggregate claim calculation could be adjusted for the rebate(s).

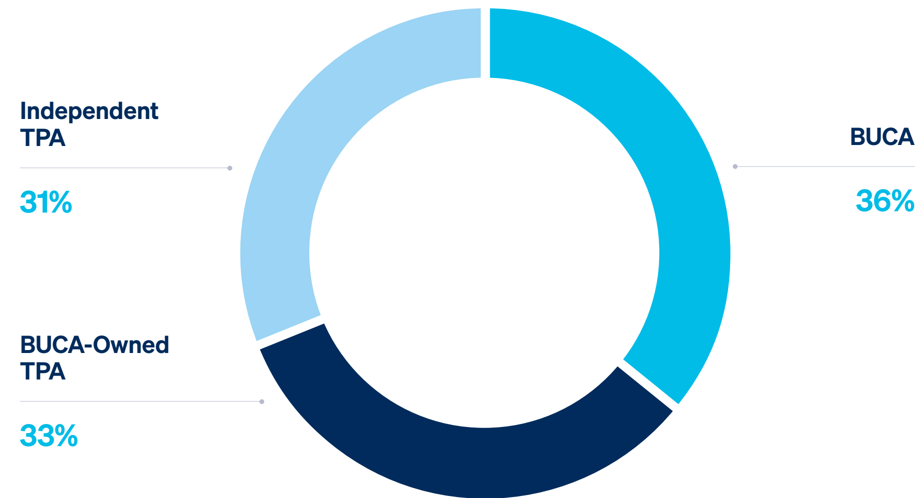
Group Size: 150
Attachment Point: $2,100,000
Total Paid (Less Spec Claims): $2,250,000
Rebates: $175,000

	Paid	Attachment Point
Claims (before any adjustments)	$2,250,000	$2,100,000
Difference between Paid and Attachment Point:		$150,000

	Paid	Attachment Point
Raw	$2,250,000	$2,100,000
Rx Rebates	$175,000	
Less Rx Rebates	$2,075,000	$2,100,000
Difference		($25,000)
Actual Aggregate Reimbursement		**$0**

In this example, the group may expect an aggregate reimbursement, since claims were over the attachment point by $150,000. However, once RX rebates were subtracted from the Paid claims, the total claims ended up under the attachment point, and therefore there was no aggregate hit.

Self-Funded Administration



Key Takeaway

Similar to last year, groups choosing self-funded administration tend to be evenly distributed across three categories: BUCA-ASO, BUCA-owned TPA and Independent TPAs. Groups selecting BUCA ASO tend to be larger — about 55%+ are covering 1,500 or more employees. Conversely, for groups with fewer than 100 employees, over 50% are with an Independent TPA. On average, a group with the BUCA network has just over 900 subscribers, while groups with an Independent TPA are about half the size.

An MGU Perspective

Amwins Benefits Exclusive Programs, a specialty stop-loss underwriter and program manager for multiple A-rated carrier partners, has contributed additional insights to this report. Benchmarking data from this reputable MGU with a 25-year track record of success in the market largely mirrors the trends shared above and reinforces the outlook on broader healthcare and cost trends. This book of business reflects similar average group sizes, distribution of groups by specific deductible ranges, and comparable election of aggregate coverage and lasers. The block does feature a higher incidence of aggregating specific deductibles (closer to one out of three groups) which reduces premiums proportionately. More than 75% of Amwins Benefits Exclusive Programs contracts are on a Paid basis, which is also consistent with the Amwins Self-Funded block.

Small to Mid-Market Insights

The following data includes Amwins Small to Mid-Market fully insured groups across a 14-state demographic. The insights below are provided by regionally-experienced sales consultants and knowledgeable service teams to help brokers gain a deeper understanding of emerging trends across the geographic markets we serve. As mentioned earlier in this report, a handful of carriers typically dominate each regional market, with some recent exits impacting competition and capacity.

$4.4B+ In-Force Premium

500K+ Lives Covered

400+ Dedicated Team Members

5,000+ Retail Relationships

Fully Insured Market Insights by Region

Healthcare is personal, and cost drivers vary significantly by geography. Specialized expertise is particularly valuable in fully insured and ancillary markets where employers may not have access to detailed claims data. Strategic partners can evaluate carrier offerings, explore transition strategies and provide meaningful expertise to best serve a shifting, multi-generational workforce.

Small group fully insured rates are publicly available and filed with each state. Proactively sharing information and setting expectations in late spring or early summer may alleviate frustration among fully insured clients prior to the busy renewal season.

Carriers actively competing in the fully insured small group space are increasingly limited, and a few notable players peeled away this past year. Some have doubled down on level funding, releasing tech-focused tools to generate risk scores and medically underwritten quotes almost instantly, while others have shifted focus to the large group space.

The following insights blend commentary from the Amwins Benefits Small to Mid-Market team with publicly available data for each market.

Northeast (CT, NY)

Prices have been stagnant in groups between one and 100, and in the larger group market, direct transactions with major retailers are most common. Primary carriers retain a strong presence in this region, with one enjoying an 85%+ lock on market share.

New York's small group market (under 101 employees) has experienced a 24% drop in covered lives between 2020 and 2024, prompting three major carriers to exit the space. Migration from the ACA market is limited mainly to PEO options.

In Connecticut, ACA trend increases landed in the low double digits, and five major carriers offering small group fully insured plans have exited the market since 2022.

Within the ancillary market, medical carriers are discounting bundled lines and retaining significant control. Bundles are popular, especially in level-funded groups, and implementation credits can sometimes move the needle.

Mid-Atlantic (DC, MD, VA)

Individual coverage is competitively priced, resulting in sluggish new business sales with micro-groups. Double-digit increases are pushing brokers and clients to move, but new business acquisition is slower than typical. Two large carriers have increased level-funding activity and another has made moves to enter the level-funded market. Offering level-funded plans to cases that may be too small raises concerns, but carriers are incentivizing clients and brokers to pursue such business. The Johns Hopkins/United Healthcare negotiation ended in an impasse in September of 2025, leaving about 60K patients to navigate potential changes to their coverage and providers.

Southeast (NC, SC, GA, FL)

The southeast was primed for alternatives to traditional ACA coverage as the dominant players continued to increase premiums. Level funding is the lead product, with major carriers also focused on growing MEWAs* and Chamber Association Health Plans. Core players have maintained fully insured blocks while new TPA entrants expanded level-funded offerings; one carrier expects a level-funded option to be presented with every renewal. All have leaned into AI-driven and self-quoting underwriting solutions to quickly offer alternatives to fully insured metallic plans, especially for the smallest groups. ICHRAs have grown in popularity at a faster pace in these markets.

In Florida, between 35% to 40% of groups renewed with the incumbent, while the majority aimed to move to alternative funding or a completely new carrier. Competitive, new players have emerged along with opportunities to cross-sell ancillary into the medical space.

Texas

Rate spikes in the high single digits started in late 2025 and picked up across the last renewal cycle. Following an extremely busy quoting season, many groups did change carriers. Small groups have been steadily migrating from fully insured to level-funded plans since the ACA market's reforms, and increased level-funded competition and carrier capacity have spurred more fully-insured-to-level-funded transitions. However, the complex process to build and manage appropriate level-funded plans has strained brokers' and employers' operational capacity. Brokers continue to educate clients from all angles and identify potential solutions (such as level-funded and HMOs) to save on costs wherever possible. Carriers with clout and weight are still likely to achieve good PPO discounts.

West (CA, AZ)

This region continues to move through a state of transition. Increased costs and state-mandated infertility benefits (California SB 729) have led more brokers and employers to explore alternate options such as level funding and PEOs. The trending growth in the large group segment will likely remain across 2026. Ancillary has been extremely competitive and ripe for growth in this region, especially between the top carrier partners who continue to engage at the case level to win opportunities.

Multiple Employer Welfare Arrangement

	Northeast	Mid-Atlantic	Southeast	Texas	West
Fully Insured ACA Small Group – Q1 2026 Average Rate Impact	**CT:** 11% **NY:** 13%	**MD:** 8.9% **VA:** 9.9% **DC:** 9.7%	**FL:** 11% **GA:** 9.2% **NC:** 13.9% **SC:** 9.5%	**TX:** 10.6%	**CA:** 9.5%* **AZ:** 13%
# of Amwins Carrier Partners in Each Region	14 medical 15 ancillary	6 medical 11 ancillary	8 medical 18 ancillary	12 medical 25 ancillary	20 medical 25 ancillary

Level-Funded Market Insights

Small to mid-market groups with fully insured plans are increasingly interested in alternative options. With access to multiple A-rated carrier partners catering to different niches — including program business, small group, level-funded, traditional, alternative risk and captives — Amwins is positioned to provide such alternatives to groups that meet the entrance criteria for each solution.

Data from our small to mid-market level-funded groups (with an average group size under 40) indicates the following:

$20K to $30K
Average specific deductible

About 7%
of business is aggregate only

Over 10%
MVP** and MEC** plans account for just over 10% of business

95%+
of contracts include run-out coverage

99%+
of groups have aggregate coverage and do not leverage aggregating specific deductibles due to the size of the business

This population deploys lasers at a low rate (less than 10%). However, the sizable relative increase in lasers in 2026 was nearly double compared to the increase in 2024. Within this segment, the average PEPM premium has trended differently from the broader market. This changing mix of the business, alternate quoting strategy and increased acceptance of lasers provided greater persistency of preferred and standard risk business.

** Excluding several regional HMOs that averaged about 30+% due to new state-mandated requirements to offer plans with infertility benefits.*
*** Minimum Value Plan / Minimum Essential Coverage.*

Best Practices & Strategic Renewal Approaches

Proactive, transparent communication is critical throughout the renewal and evaluation process, no matter the type of plan or group. This year, it is critical for brokers to proactively inform and educate clients about the emergent factors influencing the hardening market. This section includes a few of our recommended best practices related to self-funded plans and stop-loss.

Prevent Stop-Loss Claims Denials

The most common reasons for a stop-loss claim denial include:

- eligibility issues
- inconsistent administration of any and all leave policies
- insufficient documentation in employee handbooks and plan documents

Our experts strongly recommend periodically auditing dependent eligibility and ensuring leave policies are documented and administered consistently. Language must detail the dates coverage begins and ends and include specifications for leaves of absence of any type. Paid time off and non-paid leave policies must also be clearly referenced in an employer's leave policy, especially if they may run concurrently with FMLA. As highlighted earlier in this report, mandated leave policies vary from state to state.

In the Amwins Self-Funded book of business, less than 1% of stop-loss claims are fully denied.

Carriers strictly reimburse based on plan documents. Inconsistent or incomplete documentation can lead to coverage gaps while clear documentation allows for faster, less disruptive claims processing. The use of "AND" versus "OR" (or vice versa) can have big implications on coverage and reimbursement.

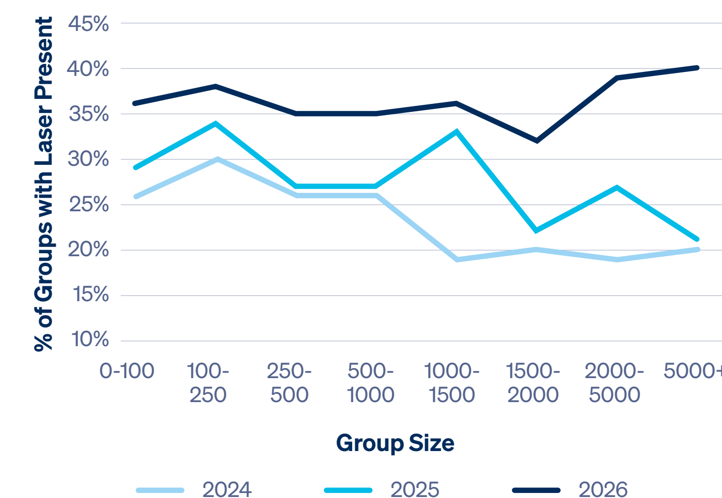
Identify High-Dollar Claims Sooner

Too often, groups are unaware of high-dollar treatments until weeks or months after care begins. At that point, opportunities to negotiate pricing or steer care may be limited or no longer possible. Advanced healthcare database monitoring can slow down a claim and redirect spending trends much earlier in the claim lifecycle — and before it snowballs. Plans become more proactive than reactive, controlling costs while still ensuring members are guided toward an appropriate treatment protocol. Outside of mitigating high-dollar claims, "auto-surveillance" reporting can be used to identify claims that are less severe, but increasing in frequency.

Understand Lasers and Strategy

We are seeing another increase in groups with at least one laser present compared to prior years. Previously, larger groups tended to have fewer lasers relative to smaller groups, but in 2025 we saw more groups between 1,000 and 1,500 lives add lasers to their policies. In 2026, this trend continued for groups over 1,500 lives. An increase in lasers may signal that carriers are becoming more conservative in underwriting, but it could also be a strategy for groups to utilize lasers as a lever to mitigate increases in stop-loss rates.

Laser Election Over Time



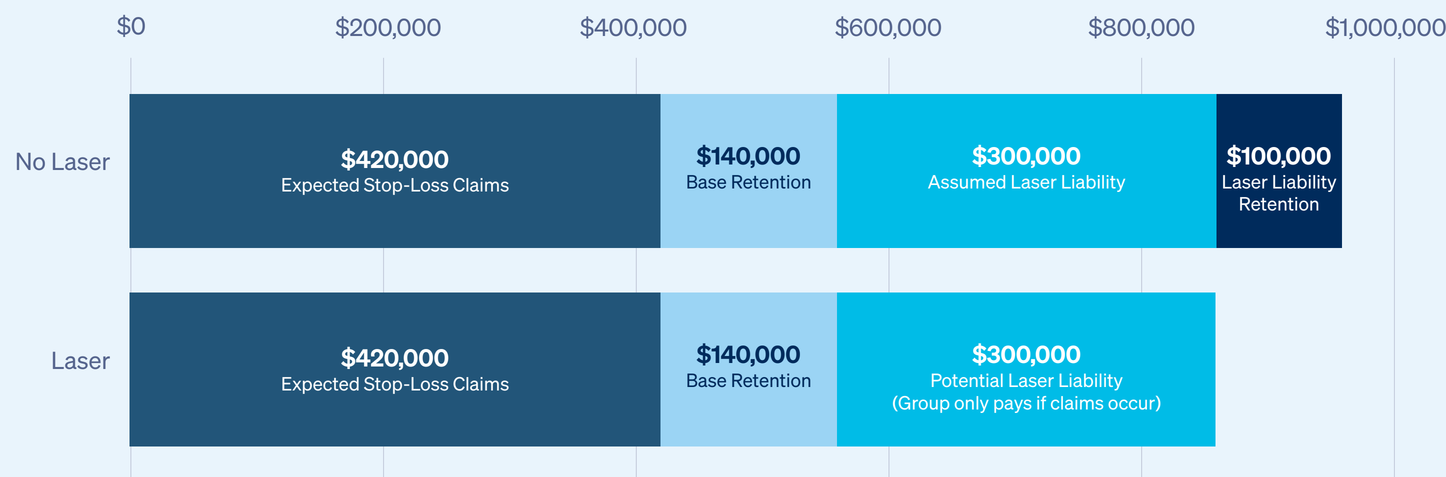
Groups with No New Laser/Rate Cap (NNL/RC) Provisions

Group Size	2024	2025	2026
0-100	44%	43%	50%
100-250	64%	71%	72%
250-500	76%	80%	77%
500-1000	76%	80%	81%
1000-1500	79%	83%	79%
1500-2000	77%	82%	87%
2000-5000	79%	82%	85%
5000+	76%	86%	83%
Total	**69%**	**73%**	**73%**

Key Takeaway
Self-insured employers, and especially mid sized ones, are seeking additional protection outside of traditional stop-loss contracts. For groups moving from fully-insured or level-funded to traditional self-funding, a rate cap is an additional layer of protection. Despite the upfront costs of purchasing additional rate cap provisions and no new laser policies, the benefit of risk transfer and/or avoidance often proves to be financially beneficial. In 2024, 69% of Amwins Self-Funded's groups had selected a NNL/RC policy; in 2025, that percentage increased to 73%; in 2026, that percentage remained at 73%. The most notable change in 2026 was the increase in NNL/RC policies for the smallest groups, up to 100 lives. This segment now has a NNL/RC in place as often as it doesn't. While anecdotally, experts note that rate caps and no new laser policy options are becoming more limited, the percentages on the Amwins Self-Funded book remain steady.

In Action | Laser and Strategy

Laser Scenario: In the No Laser option, the laser risk is built into the total cost, which includes additional retention for the laser liability, equating to **$960,000**. In the Laser option, the minimum cost is $560,000, which is equal to the Expected Specific Claims + Base Retention. Even if the Laser option hits maximum cost, the group would still be better off financially by **$100,000**.



Increase the Specific (Spec) Deductible to Offset Leveraged Trend

While not a new concept, the market has not done a good job implementing spec deductible increases and it is one of the contributing factors putting pressure on rates.

In the example to the right, assume first dollar medical trend is **8.5%.** A **$160,000** claim incurred in 2025 would cost **$173,600*** in 2026. Stop-loss carrier's liability went up by **22.6%**. This is called **leveraged trend.**

** Calculation based on $160,000 × 1.085 = $173,600.*

Explore the Spectrum of Cost Containment Strategies

In this tightening market, self-funded groups are very eager to explore available tech, tools and cost-containment solutions. Even with a strong understanding of a population or geographic market, severe high-cost events cannot be fully anticipated. Along with niche external vendors, many carriers now offer their own cost-containment programs to keep covered members "in the family."

No matter the program, understanding the available data is key to selecting the most effective cost containment strategies. Brokers are encouraged to tap into niche subject matter experts who are well-versed in innovative, financially-meaningful cost-containment programs. Our experts most frequently recommend exploring:

Dialysis Management Solutions (DMS):
End-stage renal disease (ESRD) impacts 800,000+ people in the U.S. with 135,000+ new diagnoses annually. It is not unusual for yearly billed charges to reach between $1M and $1.5M — and sometimes $2M+. Employer health plans typically pay for the first 30 to 33 months, oftentimes at PPO rates that do not yield meaningful savings. As an example, Amwins' DMS is a cost-containment program that deploys proprietary plan language and a Reasonable Value Payment methodology. It helps plans move dialysis out of the PPO network, re-price claims with confidence and integrate case management to help delay chronic kidney disease progression and reduce costs up to 90% (or more) off billed charges, including all program fees and costs.

Infusion Services (Site-of-care Optimization):
These types of programs blend healthcare database monitoring, earlier intervention, education and even direct, tangible patient incentives to redirect appropriate infusions from hospitals to outpatient facilities or in-home services. Members can still choose to receive their infusion at a hospital, but, depending on the program, may assume greater financial responsibility. Some programs send a registered nurse to meet patients where they are — at home or even at work — and offer gas cards, grocery gift certificates or transportation assistance for making the shift. Savings can range between 25% and 65% with this strategy.

Gene, Cell and CAR-T Therapy Coverage:
Amwins' GTS supplements a group's current employee health and benefits strategy. In some cases, these life-changing and life-saving treatments are the only option for babies born with debilitating and torturous conditions. Payers should not be tasked with interfering with or restricting access to care due to insurmountable cost — especially as some therapies must be administered within a very limited window. Amwins' GTS provides first-dollar reimbursement for high-cost, clinically appropriate therapies relevant to group plan participants.

Diabetes Prevention and Education:
Diabetes is the most expensive chronic condition in the country, generating more than $413B in annual medical costs. Hospitalizations, complications, medications and doctors' visits — and indirect costs such as lost productivity and disability — are just a few factors tied to the financial burden of this chronic disease. Mobile apps and medically trained care managers, counselors and nutritionists for personalized support can be deployed to help manage and control an anticipated diabetes diagnosis.

Premature Birth Prevention and Neonatal Care:
Premature infants and micro-premies can spend days, weeks or even years in a neonatal intensive care unit (NICU). A perinatal stop-loss claim may seem unavoidable, but specialized maternity healthcare management and care coordination partners may potentially prevent pre-term births. Third-party NICU specialists can also ensure care is clinically appropriate and review claims documentation for coding errors.

Consider Plan Mirroring

A plan mirroring provision helps resolve conflicts between covered expenses outlined in the health plan document and the limitations/exclusions specified in the stop-loss contract. However, it does not guarantee payment of a claim in all situations, negate exclusions listed on the stop-loss policy or reimburse for administrative fees. Confirming Plan Mirroring typically involves the stop-loss carrier reviewing and approving the Summary Plan Description (SPD). Ideally, this is done prior to the effective date, but oftentimes the review and approval happens after the effective date due to the timing of the updated final SPDs.

Ensure Adequate Run-In and Run-Out Provisions

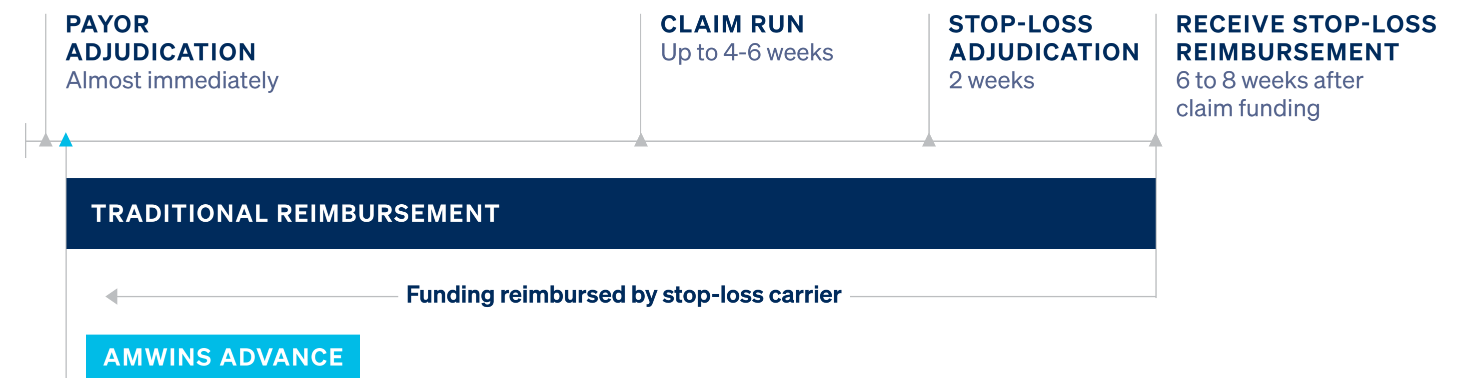
Underlying plan documents often stipulate a 12-month submission window for a provider to submit a claim, and network agreements allow providers up to a year or more to appeal reimbursement decisions. Twelve months of run-in or run-out coverage should be in place to avoid gaps and/or paid or gapless coverage can be negotiated. An appropriate contract minimizes the risk of claims falling through the cracks and aligns with the industry-wide trend of slower processing and payments.

Some groups may opt for shorter or limited run-in and run-out periods (such as three or six months) in an attempt to gain more favorable pricing. This strategy is increasingly risky. The majority of Amwins Self-Funded contracts (79%) are sold on a Paid basis.

Understand Cash-Flow Implications

Even with the benefits and financial protections of self-funding, the timing of a high-cost stop-loss claim reimbursement can disrupt cash flow and business operations. Reimbursement for a clean stop-loss claim, while not fail-proof, should average between 10 to 15 days. However, complex claims, missing data, or unclear eligibility can lead to much longer reimbursement times. Amwins Advance can help alleviate cash flow challenges in both TPA- and BUCA-administered plans and will fund claims up to $5M within 72 hours of a loss. Amwins Advance is not limited to any individual stop-loss carrier, TPA or PBM, and funds are transferred prior to receiving detailed eligibility details or claims forms.

In Action
A manufacturer with 220 employees and $100K deductible experienced its first large stop-loss claim of the year, at $2.69M. With Amwins Advance, the group was reimbursed in one day. The stop-loss carrier reimbursed the claim in 169 days.



Approach Ancillary Renewals as a Strategy, Not a Transaction

In a market where rate alone rarely tells the full story, ancillary renewals warrant the same disciplined approach that groups now apply to medical and stop-loss. Dental, vision, life/AD&D, STD, LTD and worksite/voluntary lines experienced renewal pressure in 2025 and 2026 — driven by claims volatility in disability lines, persistent dental utilization above pre-pandemic baselines and tightening underwriting on guaranteed issue. Brokers who treat ancillary as an annual checkbox often miss the opportunity to consult their clients on leave and multi-state compliance exposure, overall benefit strategy alignment with employee needs and plan design relevance to the current workforce.

Treat Carrier Vetting as a Repeatable Discipline

Selecting an ancillary carrier based solely on rate is one of the most common — and most consequential — placement errors. A defensible vetting process examines financial strength and ratings, network depth and disruption analysis (for dental and vision), absence and leave administration capabilities, benefits administration technology and integrations. The carriers winning sustainable ancillary business in 2026 have invested in transparent reporting, consultative underwriting and a service model that holds up at renewal.

Leverage Technology and Analytics as a Strategic Asset

Ancillary placements are increasingly reliant on data quality and analytics, not just on the carrier relationship. Amwins Ancillary brings a combination of proprietary market analysis tools, operational workflow systems and dedicated analytics support to move renewal conversations beyond anecdotes and into a defensible, data-anchored story.

▸ In Action | Build Compliance into the Placement, Not After It
Compliance is the fastest-growing risk in the ancillary benefits space. Regulatory pressure is accelerating on two fronts — continued expansion of state-mandated leave and statutory programs and heightened ERISA scrutiny of voluntary and worksite benefits. PFML programs have been established in 14 states and Washington, D.C., as well as statutory disability requirements in five states plus Puerto Rico. For multi-state employers, requirements differ materially by jurisdiction, impacting contribution structures, benefit coordination and minimum standards. Organizations can proactively address this complexity by reviewing statutory leave compliance at placement and renewal. Voluntary and worksite benefits require the same discipline and are subject to increased fiduciary scrutiny around carrier selection, cost-to-benefit ratio and ongoing oversight. A lack of documented decision-making and ongoing oversight can create the same exposure that drove a wave of ERISA class-action filings in late 2025. Compliance must be intentionally designed into the placement — not an afterthought.

Address Multi-State Complexity with Specialized Leave and Absence Expertise

For organizations operating across multiple states or entering new jurisdictions, leave and absence has evolved into a strategic discipline rather than an administrative task. Effective support requires integrated expertise across PFML, disability, FMLA, statutory and ADA programs, including multi-state compliance design, plan document review against statutory minimums and carrier alignment to a group's geographic footprint and absence philosophy. A consistent, team-based service model supported by strong analytics, technology and compliance infrastructure enables continuity, accountability and full life cycle support for the growing complexity of ancillary benefits.

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As an industry, carriers, brokers, partners, and plan administrators share a responsibility to maintain appropriate, high-quality benefits coverage options for individuals and families.

Self-funded plans allow for more flexibility in plan design and structure and a group's renewal is driven primarily by its specific claims experience. In contrast, fully insured renewals are influenced by pooled risk adjustments, carrier underwriting methodology and broader market changes.

Smaller and mid-sized groups do not have visibility into detailed claims data but they do have access to industry partners with niche expertise and deep regionally-based perspectives. GAs are becoming increasingly valuable — particularly when relevant data is limited — and brokers do not have to navigate the dynamic and continually evolving industry alone.

Amwins offers a comprehensive portfolio of products and solutions to help employers of all sizes effectively balance risk, cost and employee needs. The breadth of our service lines enables us to recommend a thoughtful strategy to best align with an organization's specific goals and needs.

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Amwins would like to acknowledge the following individuals who contributed to this report:

Riva Dumeny, President, Amwins Benefits Division
John Robinson, VP, Strategy, Amwins Benefits Division
Jeremy Fife, CEO, Amwins Self-Funded
Scott Case, COO, Amwins Self-Funded
Wright Dickinson, President, Amwins Exclusive Programs (Large Group)
Vicki Schmelzer, President, Amwins Exclusive Programs (Small Group)
Adam Mathis, President, Amwins Small to Mid-Market
Bryan Herman, CEO, Amwins Ancillary
Chris Wirth, President, Amwins Ancillary
Mark Acquadro, President, True Benefit
Jennifer Cordes, Assistant General Counsel, Amwins Benefits Division
Abigail Caldwell, SVP, Health Actuary, Amwins Benefits Division
Lidia Shestakov, Director, Health Actuary, Amwins Benefits Division
Jack Tyson, Health Actuary, Amwins Benefits Division
Michael Hopkins, EVP, Relationship Management, Amwins Self-Funded
Anna Leifeld, Regional President, Amwins Self-Funded
Meredith Hunter, SVP, Specialty, Amwins Self-Funded
Michael Monnich, Regional President, Amwins Self-Funded
Scotty Campbell, EVP, Amwins Self-Funded
Scott Kilpatrick, President, Amwins Small to Mid-Market
Ronnie Kilpatrick, SVP, Amwins Small to Mid-Market
Caroline Branch, SVP, Product Owner, Amwins Small to Mid-Market
Michael Gates, VP, Sales, Amwins Self-Funded
Justin Goodwin, VP, Sales, Amwins Retiree Healthcare
Donald Lee, SVP, Amwins Benefits Division
Jack Lyons, SVP, Amwins Small to Mid-Market
Mona Mehta, VP Business Development, Amwins Small to Mid-Market
Georges Markarian, Consultant, Amwins Benefits Division
Jenette Schafer, VP Ancillary Strategic Partnerships, Amwins Ancillary
Kevin Timone, EVP Sales, Amwins Small to Mid-Market

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