

A Broker's Guide

Transitioning to Self-Funded

The Ultimate Playbook for Evaluating Opportunity and Transitioning Groups from Fully Insured to Level-Funded, Captive, or Self-Funded Health Plans

Designing Benefits | A Reference Guide

This guide contains a step-by-step look at identifying potential candidates, performing member-level analysis, building the right plan structure, recommending the right partners, and developing strategies for successful placements.

Our team delivers the services, technology, and expertise at every step of our evaluation process to skillfully architect the right solution for even the most complex group — vendor and product agnostic, we help our brokers assemble the right combination of stop-loss, TPA, PBM, cost containment solutions, and plan design for each group. And, if the data says self-funding isn't the right move, we'll tell you that too. Amwins Benefits delivers solutions for all possible plan designs.

► Strategic Benefits Planning Matters Now More Than Ever

The fully insured market has fundamentally changed. On average, employers are absorbing annual premium increases of roughly 8–15%¹ ([read more in our 2026 State of the Market Report](#)) with little transparency into what's driving the cost increase, and in good claim years the carrier — not the employer — keeps the savings.

That pressure is fueling real demand. More employers are actively asking about level-funding, captives, and self-funding than ever before. The renewal conversation is a natural entry point to introduce an alternative funding strategy and strengthen the relationship.

This document is to support our brokers with plan sponsors who are curious about self-funding but don't yet know how to get there.

As your partner, Amwins Benefits brings a highly educational and analytical approach to this process so you can have a confident, consultative conversation with your clients.

Fully Insured

Level-Funded

Captive

Self-Funded

1. Based on Amwins Benefits' claims administration experience across stop-loss book of business.

► Fully Insured, Level-Funded, Captive & Self-Funded Solutions

Think of these four solutions as points along a single continuum of risk and control. Many groups don't jump straight from fully insured to self-funded — level-funding or a captive arrangements are often steppingstones that build claims data and comfort along the way.

► Continuum of Risk Control

Fully Insured

Carrier assumes the risk; premiums are fixed and fully guaranteed.

Level-Funded

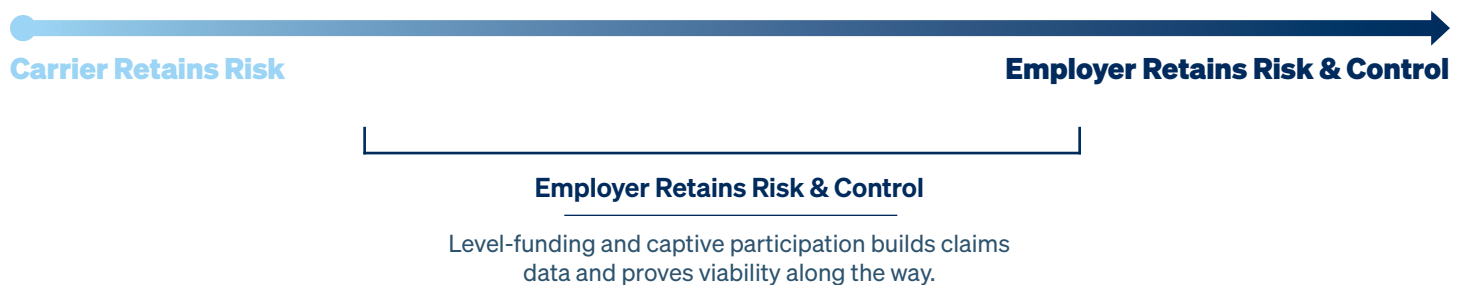
Fixed monthly cost with a year-end settlement; starts building claims data.

Captive

Employer joins a group risk-sharing pool for more transparency and control.

Self-Funded

Employer retains the risk and has full control over plan design and dollars.



Funding Structures We Place

The best structure follows the data!

► Fully Insured

By paying a fixed premium, the employer transfers essentially all claims risk to the carrier — a single, predictable line item that simplifies budgeting and protects cash flow from the month-to-month swings a Self-Funded arrangement can potentially bring. Fully insured coverage can also be the right fit for groups whose size or risk profile doesn't yet support self-funding — making it both a sensible long-term choice for some and a reasonable holding position for others until the data shows they're ready to take on more risk.

[View Small to Mid-Market Solutions](#)

► Level-Funded

A predictable monthly payment that feels like a fully insured premium, with a self-funded plan underneath. There is a potential refund to the employer if claims run below the projection. This is best for smaller groups (often under 50) or employers not yet ready to absorb direct claims variability.

Level-funded plans give employers a self-funded plan's cost transparency and savings potential, wrapped in the predictability of a fully-insured premium. Each month, the employer pays a fixed, level payment that covers three components: expected claims, administrative fees, and stop-loss premium — so budgeting looks and feels just like traditional insurance.

The difference shows up at year-end: if actual claims come in under the projected amount, the employer gets some or all of the surplus back as a refund. If claims run high, stop-loss coverage kicks in to protect the employer from the overage — so the downside risk is capped, not open-ended.

This structure makes level funding a natural stepping stone for small and mid-size employers who want a taste of self-funded savings and claims transparency without taking on the full volatility and reporting complexity of a traditional self-funded plan. It's often the entry point for groups that later graduate to full self-funding or a captive arrangement as they gain size, data, and risk tolerance.

The Level-Funded Playbook

► Captives (Group, Association & Agency)

Group Captives

A group captive is an insurance company formed and owned collectively by multiple unrelated businesses that come together to insure a common risk — most often property/casualty lines in the commercial world, or medical stop-loss in the employee benefits space. Rather than each member absorbing full risk alone (self-insurance) or handing all of it to a commercial carrier (fully-insured), group captive members pool a defined layer of risk together, share underwriting profit when claims run favorably, and access reinsurance to cap the downside.

Group captives typically work best for mid-size organizations — too large to get competitive pricing in the fully-insured market, but not large enough (or risk-tolerant enough) to form a single-parent captive on their own. By joining forces with similar-sized peers, members get access to:

- **Underwriting profit-sharing** — money that would otherwise go to a commercial insurer's bottom line comes back to members instead
- **Greater control and transparency** — visibility into claims data, loss trends, and program performance that fully-insured buyers rarely get
- **Risk-sharing without full pooling** — losses are typically shared only within a defined layer, with reinsurance or stop-loss protecting the group above that
- **Access to loss-control and safety resources** — many group captives invest heavily in member risk-management support, since better member performance benefits everyone in the pool

Group captives come in several structural flavors depending on who organizes and sponsors them — two of the most common are association captives and agency captives.

Association Captives

An association captive is formed by members of a trade association, industry group, or professional organization who share a common business type and, often, a common risk profile. Because members already share an affinity — same industry, similar operations, similar exposures — underwriting can be more precise, and loss-control programs can be tailored to risks the whole membership faces (e.g., a trucking association captive addressing fleet safety, or a healthcare association captive addressing malpractice exposure).

Key characteristics:

- Sponsored and often governed in partnership with the trade association itself
- Membership in the captive is generally limited to (or prioritized for) association members
- Underwriting benefits from homogeneous risk — similar businesses tend to have more predictable, comparable loss patterns
- Association involvement can add credibility and distribution reach, since the group captive is marketed through an established membership base

Agency Captives

An agency captive is sponsored by an insurance agency or brokerage, which recruits its own client base to participate in the captive. Rather than an industry affinity binding the group together, it's the agency's existing book of business and relationships that form the captive's membership. The agency plays an active role in program design, member recruitment, and ongoing service — and in many structures, shares in the captive's underwriting profit alongside members, aligning the agency's incentives with long-term loss performance rather than just premium volume.

Key characteristics:

- Sponsored and driven by the agency/broker, not a trade association
- Membership draws from the agency's client relationships, so risk profiles can be more varied than an association captive
- The agency typically retains an active advisory or governance role and may participate financially in captive performance
- Gives agencies a differentiated retention tool — clients get access to a captive program they can't get by shopping elsewhere, deepening the agency relationship

Captive Solutions By Amwins

A Better Benefits Experience



Amwins Benefits has 5 solution verticals and can help position you for success with products and services across **Small to Mid-Market**, **Self-Funded**, **Ancillary**, **Exclusive Programs** and **Retiree Healthcare?**

It's the most comprehensive suite of expertise, products and services in the market!

► Traditional Self-Funded + Stop-Loss

The employer pays claims as incurred, protected by a specific deductible and an aggregate corridor. This is often the best solution where the probability of outperforming fully insured is strong and the employer group's cash flow can absorb monthly variability. Self-Funded structures often come with a variety of other advantages such as premium tax savings and plan design flexibility.

Premium Tax Savings

When an employer buys a fully-insured plan, the insurance carrier pays a state premium tax on the premiums collected — typically 2% to 3.5% depending on the state² — and that cost gets baked directly into the premium the employer pays.

Self-insured plans don't pay this tax because the employer is technically paying claims directly (often through a TPA) rather than buying "insurance" in the regulatory sense, and because ERISA preempts state insurance regulation for self-funded plans, there's no premium to tax. That 2-3.5% is simply avoided — not deferred, not shifted, gone.

For a mid-size employer with several million dollars in annual claims spend, that alone can be a meaningful six-figure savings.

Benefits & Plan Design Flexibility

Choosing the self-funded option for a company typically allows for more room for customization that can be more precise in benefiting a specific employee population.

- Choose exactly which services are covered, at what levels, with what cost-sharing — not constrained by state-mandated benefits.
- Design tiered or narrow networks, reference-based pricing, or direct contracts with specific providers/health systems
- Build custom wellness incentives, telehealth-first structures, or condition-specific cost containment carve-outs (diabetes, MSK, fertility, etc.)

Additionally, Self-Funded arrangements have:

- Multi-state consistency
- Structured cost sharing
- Vendor or network flexibility
- Speed and improvement superiority

[View Amwins Self-Funded Solutions](#)

2. NAIC's Compendium of State Laws on Insurance Topics — Premium Tax Rate by Line (the actual state-by-state rate table: content.naic.org).

► Plan Design & Risk Breakdown

	Fully Insured	Level-Funded	Captive	Self-Funded
Who holds the risk?	The carrier assumes all financial risk and pays all eligible claims	The employer self-funds underneath, but a fixed monthly payment smooths the risk	The employer retains a layer of its own risk and shares a pooled layer with other employers	The employer assumes the financial risk and funds claims as incurred
What the employer pays	Fixed premiums regardless of actual utilization	A predictable monthly amount covering expected claims, stop-loss premium, and admin	Its own claims to a retention, a contribution to the shared layer, plus stop-loss and admin	Actual claims as they occur, plus stop-loss premium and admin
Upside in a good year?	Carrier keeps the savings	Employer typically receives a refund if claims come in below projection	Employer keeps its own savings and may share in the captive's pooled profit	Employer retains the savings
Data & transparency	Limited visibility into cost drivers	Some claims data begins to accumulate	Full access to its own data, plus pooled benchmarking across captive members	Full access to all claims, drug utilization, and cost trends
Regulation	Subject to state insurance laws, mandates, and premium taxes	Self-funded underneath; generally governed by ERISA	Governed by ERISA, with the captive subject to its domicile's regulation	Governed by ERISA; exempt from many state regulations
Fiduciary responsibility	Minimal for the employer — the carrier bears claims-payment risk, so ERISA fiduciary duty is largely limited to prudent carrier/plan selection and administration oversight	Employer is generally the ERISA plan fiduciary for the self-funded layer beneath the arrangement, though the carrier/TPA's claims processing and stop-loss wrap narrow day-to-day exposure	Employer holds full ERISA fiduciary duty for its own plan, plus an added governance layer at the captive level (board participation, member agreements) tied to the shared risk pool	Employer holds full ERISA fiduciary duty — prudent plan administration, claims oversight, and use of plan assets — typically the highest fiduciary exposure of the four
Plan design flexibility	Set by the carrier	Limited customization	Broad flexibility, within the captive program's parameters	Complete flexibility to design for your population
Stop-loss	Not typically required	Built into the fixed monthly payment	Specific stop-loss per member, with excess stop-loss protecting the captive layer	Specific and aggregate stop-loss purchased to cap exposure
Best fit	Groups not ready to take on any risk	Smaller groups (often under 50) or those easing toward self-funding	Groups competitive enough to self-fund but that benefit from pooling and stability	Groups with sufficient cash flow and favorable risk where the modeling supports it

Quick Qualification Screens

Group size

Groups of 50+ employees are candidates (not applicable in all states); 150+ are well-suited for traditional stop-loss; 250+ start to gain meaningful statistical credibility. Smaller groups often begin by transitioning from fully insured to level-funding as an intermediate step.

Financial readiness

It's important for a company to have consistent cash flow and financial reserves to absorb monthly claim variability, and an appetite to take on risk in exchange for control and upside.

Workforce profile

A relatively healthy population with reasonable utilization and a favorable age/gender mix improves the odds. Total participation, low workforce turnover, and industry are also important factors for consideration.

Trigger points

It's typical to see these arise from group growth (e.g., crossing 200–400 lives), broker or client awareness/pressure (captive or self-funding inquiries), or a competitive threat in the market. Introduce the idea early on to provide education and a level of comfort.

The Amwins Benefits Value

More Available Options

Vendor and solution agnostic, we're focused on architecting the right solution, for all profiles.

A Consultative Approach

Through deep collaboration and expert evaluation, we help you find the right solution — not sell you one.

Claims Advocacy

The number one cause for denials in stop loss is related to eligibility.³ Our team protects plan members.

Performance Solutions

Our robust portfolio changes the risk profile and creates protection advantages for the groups and the carriers.

Partner Leverage

We suggest strategies that benefit the plan sponsor and leverage our long-term carrier partnerships.

Market Access

Regardless of the available data, we have access to carriers that specialize in transitioning groups.

One Stop

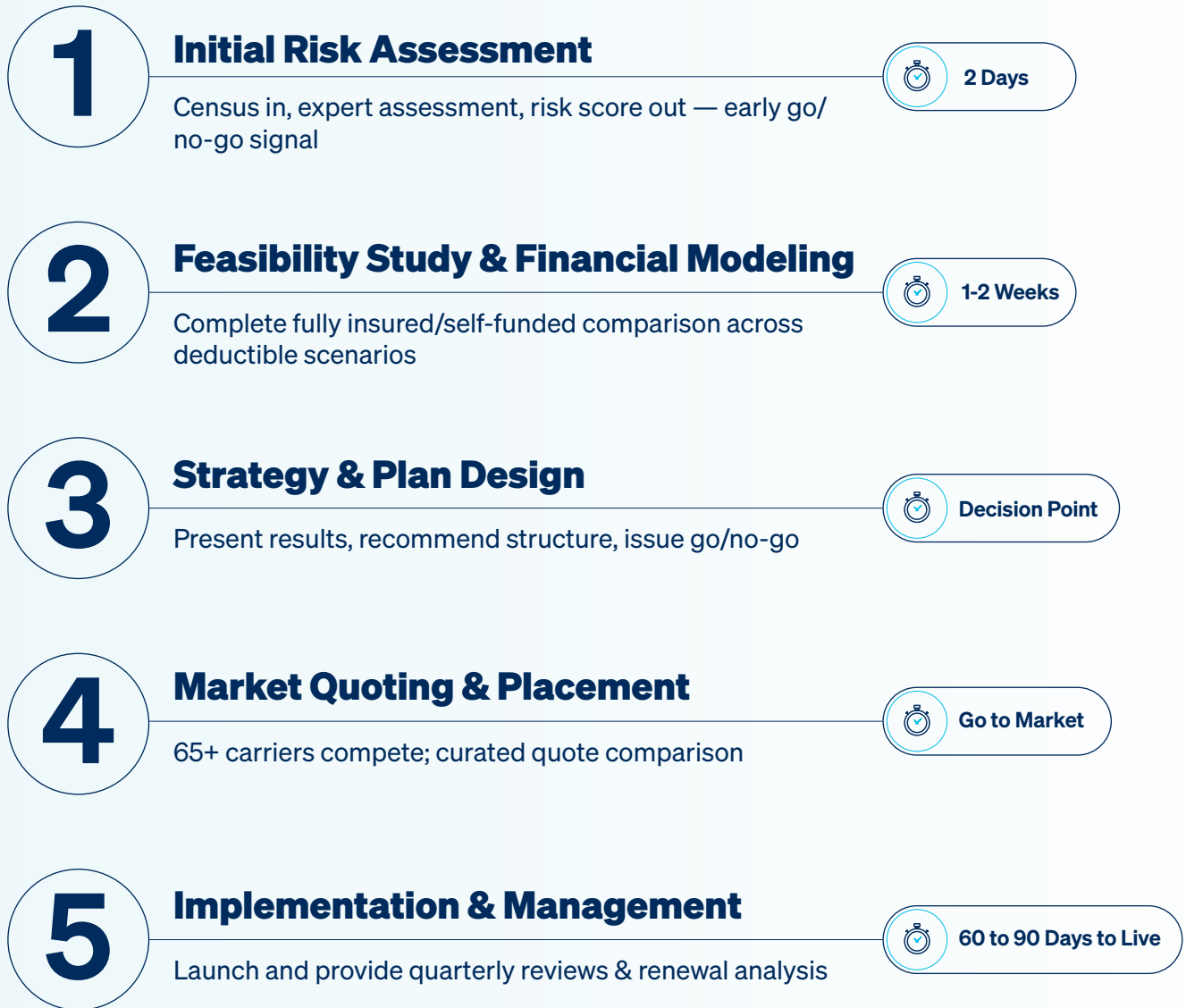
Whether it's fully insured, level-funded, captive, or self-funded, our teams are aligned internally to bring an unprecedented amount of experience across the entire benefits spectrum. We can present a single, unified recommendation.



3. Based on Amwins Benefits' claims administration experience across stop-loss book of business.

The 5-Stage Transition Process

We have a proven, repeatable process that provides clarity at every decision point. Each stage has defined inputs, deliverables, and timing — so you always know what happens next.



The Amwins Benefits team is here to help you guide employers through every stage of the transition to alternative funding, from a two-day initial risk assessment through a detailed feasibility study and financial modeling, into strategy and plan design, competitive market quoting across 65+ carriers, and finally implementation with ongoing quarterly reviews and renewal analysis.

Our structured, five-stage process gives your clients a clear go/no-go decision point at every step, and our depth across underwriting, actuarial modeling, and carrier relationships means groups could move from evaluation to a live plan in as little as 60 to 90 days — with the data and confidence to know it's the right move!

Stage 1

Initial Risk Assessment

 Powered by Amwins Benefits experts & Gradient AI

The Amwins Self-Funded Experts

At the earliest stage of the conversation — before an employer commits time, money, or political capital to a funding change — our consultants turn uncertainty into clarity by evaluating whether a funding transition makes sense. Additionally, drawing on tools like Gradient AI's predictive pre-screening, they quickly surface a group's morbidity, demographic, and high-cost-claimant exposure, then translate it into a valuable qualification signal and a recommended structure. Because Amwins consultants are vendor- and solution-agnostic, that early guidance isn't steered toward a single product; it's an objective look at whether fully insured, level-funded, captive, or self-funded best fits the group's size, risk profile, and readiness.

The result? Our experts save brokers and employers from chasing a strategy the data won't support — and when the opportunity is real, they frame it with the analytics and credibility needed to move the conversation forward with confidence.

Data-Backed Decision Making with Gradient AI

The Gradient AI analysis can be used as a pre-screening tool for fully insured groups with limited claims data interested in pursuing level-funded, captive, or self-funded arrangements. The results of the analysis will help inform whether a group appears prepared before engaging in more detailed underwriting, pricing, and structural analysis.

This pre-screening step allows us to:

- Identify groups with demographic or morbidity profiles that may be materially outside of acceptable carrier thresholds
- Assess potential risk concentration and exposure to high-cost claim drivers early in the process
- Allocate underwriting and actuarial resources more efficiently by focusing on groups that are in the best position to transition

How it Works

Gradient AI maintains access to a large, national claims clearinghouse containing claim-level data sourced from carriers across the United States. This database is used to evaluate the expected risk profile of a prospective group by comparing the member-level census to medical and Rx claims activity.



The Gradient results do not replace formal underwriting or actuarial projections, but rather serve as an early, data-driven lens to support decisions about, and prioritization within, the transition process.

Importantly, the process is HIPAA-compliant:

- PHI goes in for matching, but No PHI comes out — all results are fully de-identified and aggregated

Census Matching & Match Rate

The provided census is compared against Gradient's database to identify historical claims associated with individuals who match on key identifiers.

- The Match Rate reflects the percentage of members for whom at least one historical claim is identified
- For example, a 90.0% match rate means that claims were found for 9 out of every 10 members
- Higher match rates generally increase confidence in the resulting outputs, while lower match rates may reflect limited historical utilization or data availability

What Makes a Good Case?

Factors that impact the attractiveness of the group

[Download Gradient AI Reporting](#)

Group size

- Transition analysis is best suited and most likely to produce favorable results for groups of 100-150 (or more) lives
- Participation rate: large groups with low participation may indicate anti-selection

Industry

Geographic area

Network

- If transitioning to self-funded, will network and/or reimbursement structure change?
- What is the expected impact to costs and utilization?

State specific regulations

- Can impact feasibility for self-funded groups (ex. CA, <100 lives)

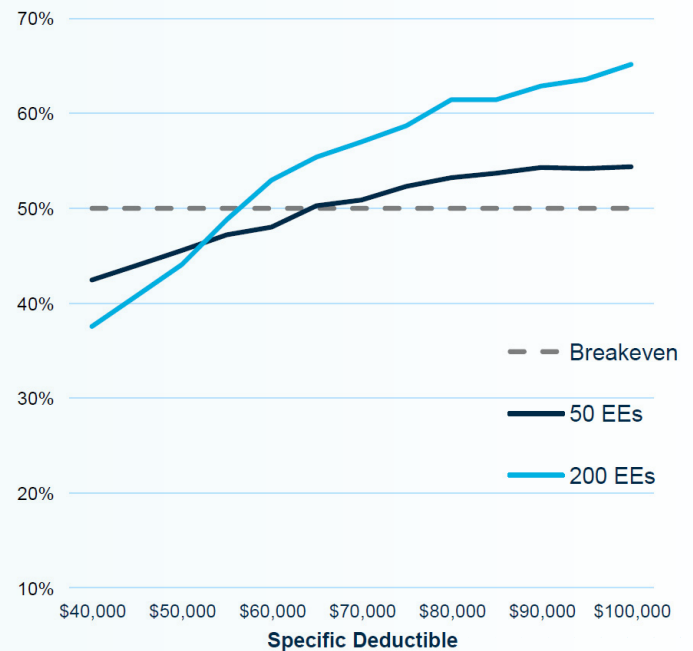
Risk appetite and commitment to self-funding structure

- Savings may not be significant in year 1

Repeat prospect

- We recommend only refreshing every 2-3 years.
- Annual refresh warranted when there is:
 1. Significant change in membership (+/- 10%)
 2. Claim level changes beyond expected claim inflation
 3. Significant benefit changes
 4. Carrier changes
 5. Major stop loss contract changes
 6. Mergers/acquisitions

Likelihood of Beating Fully Insured Arrangement*



**This example is a benchmark only; factors such as group demographics, industry, geographic location, network discounts, benefit plans, etc. will ultimately shift the height and the slope of these lines*

Stage 2

Feasibility Study & Financial Modeling

Powered by Amwins Benefits utilizing Claros Analytics

This assessment stage evaluates against traditional Fully Insured as the base.



NOTE: This takes place IF and only if the sales team determines the actuarial assessment is necessary and is aligned with the actuarial team on each opportunity.

Comparing Specific Deductibles

Using **Claros Analytics** and group's specific information (census, FI rates, benefit design, quotes, rates, historical claims' experience if available), our team delivers a fully illustrated comparison of self-funded vs. fully insured strategies, designed to quantify both savings potential and risk exposure.

We model multiple specific deductible scenarios (e.g., \$75K, \$85K, \$100K) to identify the optimal balance between risk retention and total cost.

Each scenario is calibrated to the group's profile. We project mature plan costs at renewal under fully insured and traditional self funding arrangement and compare the two.

Our analysis provides a clear, data-driven view of whether self-funding is a viable and advantageous strategy—today and over time.

Each analysis includes:

- Expected Self-Funded Plan Cost (claims + stop-loss + admin)
- Projected/expected plan costs (\$ and %)
- Probability of Outperformance vs. Fully Insured (in years 1, 3, and 5)
- Expected Number of Claims Above the Specific Deductible
- Likelihood of an Aggregate Claim / Corridor Breach
- Fixed Costs Breakdown (stop-loss premium + admin PEPM)
- Aggregate Corridor Modeling (typically ~25%)



These outputs allow for a comprehensive view of total liability, volatility, and downside risk, not just expected cost.

To produce a complete report, we typically require:

- 120+ covered lives
- Fully insured (for transition analysis) or self-funded with stop-loss (for comparison)
- Industry / SIC code
- Effective date
- Target specific deductible(s)
- Census file (age, gender, zip, coverage tier, plan elections)
- Medical & Rx plan designs (SBCs or plan grids)
- Fully insured rates (current + renewal, history if available)
- Monthly claims w/ enrollment (if available)
- Stop-loss quotes (current + renewal, if available)

Stage 3

Strategy Development, Consultation & Plan Design

 Led by the Broker + the Self-Funded Specialist

Results from Stages 1 and 2 are presented in a formal strategy meeting with the decision-makers. We walk through the recommended funding structure (traditional stop-loss, captive, or level-funded), discuss the right contract type, and review plan-design options — network, benefit structure, cost-sharing, wellness, and PBM strategy.

Aggregate coverage is evaluated against benchmarks (**86% of groups under 250 employees elect aggregate coverage**)⁴, the employer's financial capacity and administrative readiness are assessed against a structured checklist, and a clear recommendation is issued — grounded in the analytics.

Stage 4

Market Quoting & Stop-Loss Placement

 Led by Amwins Benefits | Self-Funded Team

With approval to proceed, we submit the case to **select stop-loss carriers simultaneously** — drawing on robust access to **65+ carrier markets** to create competitive tension and secure the best rates for the group's risk profile. We solicit both specific (individual claim) and aggregate (total liability) quotes, and evaluate them across deductible levels, aggregate corridor, contract type, laser/no-new-laser provisions, and terminal liability options. Often, our team will compare and contrast these against the fully insured market to ensure that we're providing the best, most advantageous arrangement for your clients.

Our team negotiates on your behalf.

Our team presents a curated quote comparison with a clear recommendation.

Our team coordinates TPA selection and PBM contracting in parallel.

Selecting the right TPA and PBM is one of the most consequential decisions in a self-funded plan, because these partners directly control cost, service, and compliance outcomes that a fully insured plan sponsor never has to think about. The TPA drives claims accuracy, network access, reporting transparency, and the day-to-day member experience — a weak TPA means slow claims turnaround, poor data visibility, and blind spots in utilization that make renewal negotiations harder. The PBM decision carries even more financial weight given how much of total plan spend now runs through pharmacy, particularly specialty drugs; contract terms around rebates, spread pricing, formulary control, and audit rights can swing costs significantly and aren't always transparent at first glance. Because self-funded sponsors bear the risk directly, misalignment between the TPA, PBM, and the employer's goals shows up fast in loss ratios and employee complaints — and unwinding a bad vendor relationship mid-plan-year is disruptive and costly. Getting the fit right up front, with contract terms and reporting capabilities vetted carefully, is what makes the rest of the plan's cost containment and compliance strategy actually work.

4. Based on Amwins Benefits' claims administration experience across stop-loss book of business.

Stage 5

Implementation, Onboarding & Ongoing Management

 Led by the Broker + TPA + Amwins Benefits Specialist team

We bind the stop-loss coverage and coordinate closely with your TPA on full implementation — data feed setup, reporting cadence, and reimbursement workflows — so claims data and stop-loss protection are aligned from day one. From there, quarterly claims and utilization reviews monitor performance against projections, high-cost claimant case management and disease management activate as warranted and stop-loss reimbursements are tracked in partnership with the TPA.

Renewal analysis begins 120 days before the plan anniversary using actual claims data, with year-over-year benchmarking against the Amwins Benefits book to refine the future strategy.

Discovery & Next Steps

Getting started takes minimal effort from the employer; the analytical lifting is on our benefits experts and our technology partners. What we need...

1. **Current employee census** — name, date of birth, gender, and ZIP code to begin pre-screening.
2. **Current fully insured premium and rate structure** — we'll build an accurate FI/SF comparison.
3. **24–36 months of historical claims data** (if available) — this strengthens the underwriting submission and improves quote competitiveness.
4. **Target effective date** — we'll build the timeline from here.
5. **30-minute kickoff meeting** — with Amwins Benefits to align on goals, structure, and timeline.

Our Commitment

We recommend self-funding only where the data supports it. Our process runs on independent analytics, competitive market access, and transparent modeling — and if self-funding isn't the right answer today, we'll tell you, and keep the door open for when it is.



Plan Sponsor FAQ

► How much does self-funding actually save?

It depends on group size, claims experience, and the chosen deductible. For groups with favorable morbidity and demographics, Year-1 savings of 5–15% are achievable⁵ — but our models are built to deliver the right insights. If the data says self-funding will cost more, we'll say so. Transitioning to a self-funded design is a long-term strategy. While savings in the first 12 months are likely, the real benefit of the move is continued savings through better plan management that comes with access to plan data.

► What happens if claims are catastrophically high?

Two layers of protection: specific stop-loss reimburses individual claims above the deductible, and aggregate stop-loss caps total plan liability for the year. The employer is never exposed to unlimited liability.

► Is the group too small?

Generally, 50+ are candidates (in most states), 150+ are well-suited for traditional stop-loss, and 250+ gain real statistical credibility. Smaller groups often start with level-funding. Our custom analysis strategy will provide a clear answer for any group.

► How long does it take?

The Initial assessment and modeling complete within 1–2 weeks of census delivery. From go decision to effective date, most groups finish in 60–90 days — and we manage the process throughout the timeline.

► Will employees notice a difference?

In most cases, no. Same network, same ID cards, and the plan design can mirror the prior plan exactly. The change is behind the scenes — the employer transitions to become the plan sponsor rather than a policyholder.



A Better Benefits Experience

Contact your local Amwins Benefits Representative or visit our website to learn more about what Amwins Benefits has to offer.

5. Amwins Benefits modeling via Claros Analytics; results vary by group size, claims experience, and deductible selection.