stealth PARTNER GROUP

An Amwins Company

Driving Proactive Strategies

Stop Loss

State of the Market Report

May 2025

Introduction and Overview

This Year's Report Highlights:

Healthcare costs continue to escalate, and employers, brokers and insurers are faced with increasing pressure — as well as timely opportunities — to adapt.

Systemic shifts in the healthcare industry, including pervasive provider shortages, the emergence of high-cost specialty therapies and treatments, climbing prescription drug usage and overall medical inflation are just a few of the factors influencing how employee health plan risk is predicted, managed and funded.

Today's savvy employers understand the benefits of flexibility in plan design, the need for solid data, and the custom cost controls a self-funded strategy can provide. While self-funded employers can exert more control over their healthcare spending, that control comes with risks.

One or two shock claims of any type — a premature infant, cancer diagnosis, in-patient stay or severe infection — will mark significant issues for groups without a proper cost-containment strategy and contract protections. Stop loss protects from such considerable risk, and — despite the market's challenges — continues on a steady, upward trajectory.

Legislative developments, data transparency mandates, soaring prescription drug costs, site of care differentials, carrier insights and tightening fiduciary standards are noteworthy topics explored in more detail throughout this year's report.

Stealth Partner Group benchmarking data — with key insights from stop loss experts, actuaries and partners — is included beginning on page 22.

Educated brokers must be prepared, perhaps now more than ever, to design effective plans and align employer groups with appropriate coverage. Brokers can leverage the information in this report — along with informed, specialized subject-matter experts and the extensive database of Stealth — as they proactively advocate for their clients in the year ahead.

Economic Conditions

Healthcare Expenses and Medical Inflation

Again this year, inflation continues to affect nearly every person and industry in the country. Medical cost inflation typically outpaces overall inflation metrics but slowed between 2020 and 2023. In 2024, medical inflation began to rise, edging very close to — and almost even with — broader inflation metrics at the time of this report. An anticipated post-COVID utilization spike paired with large-scale, systemic investments into health services and technology (HST) is expected to continue driving medical costs in the near term.

Healthcare spending increased by 7.5% from 2022 to 2023[1] and the most recent Fortune 500 list included 44 healthcare companies. Approximately 17.6% of total economic spending is attributed to healthcare, yet current utilization is still 7% below pre-COVID levels.[1]

As mentioned in our 2024 report, an aging physician workforce, nursing shortages and healthcare access disparities (especially in rural regions) continue to impact price and care. A shifting payer mix and continued renegotiation of "stale" provider contracts will play into the cost, quality and coverage dynamic.

Hospital utilization for high-cost surgical procedures has yet to return to pre-COVID levels. Experts anticipate that a shift toward outpatient facilities, ambulatory surgery centers, and in-home care can potentially prevent hospital utilization spikes in the foreseeable future.

Prescription drug spending continues its aggressive upward trajectory, fueled by GLP-1s, specialty drugs and biologics for common conditions such as obesity and diabetes and rare diseases like spinal muscular atrophy and duchenne muscular dystrophy.

The research, development and U.S. Food & Drug Administration (FDA) review process — once stalled by the Pandemic — has regained momentum, though the pace may fluctuate again. Novel drugs and innovative therapies coming to market in the next five years will push systemic boundaries as real-time case studies in patient adoption, efficacy and risk unfold.

While employee healthcare coverage can be viewed as an investment into individual workers and their families as well as a tool to attract talent, group benefits are a significant expense, no matter an organization's size.

According to Kaiser Family Foundation (KFF)[2], the combined employer/employee annual average cost to cover an individual worker is $8,435. Family coverage averages $23,968. Per-enrollee spend by private insurers is rising much faster than per-enrollee spend within the Medicare and Medicaid programs, and private employers have borne a greater proportion of the across-the-board cost increases than employees.[2]

Private health insurance accounted for approximately 30% of the country's $4.9T total healthcare spend in 2023, according to the most recent publicly accessible data available from the National Health Expenditure Accounts (NHEA).

▸ What is Health Services and Technology (HST)?

HST is a broad term that describes the blend of science, engineering, analytics, and medicine used to solve complex problems in human health.

Legislation, Policies and Impacts

As the political environment continues to shift, it is impossible to predict how — or to what extent — changing priorities, initiatives and actions will impact the healthcare and insurance industries. In the President's address to Congress in March 2025, the rising rates of autism and childhood cancers were highlighted, as was the current administration's desire to address inflation, simplify legislation and reduce national expenditures and debt.

Congressional initiatives impacting the healthcare and insurance industries may become more relevant in the next 12 to 24 months. Ongoing discussions about changes or limits to employer tax incentives for health insurance could have significant implications for the market. Transparency, disclosure and fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA) will also be noteworthy considerations, especially in the years ahead.

Employer-Sponsored Health Insurance (ESI) Tax Exclusion

Employer-paid health insurance premiums and other health-related accounts are exempt from federal income and payroll taxes. While this tax exclusion supports the widespread availability of employer-sponsored health insurance, it is estimated to cost the federal government more than $300B annually. Replacing, modifying or limiting the ESI Tax Exclusion credit may weaken the incentive for employers to offer coverage.

The Congressional Budget Office (CBO) has proposed that contributions over certain limits be taxable income starting in 2026, and economists and actuaries have investigated a variety of scenarios to predict related implications on tax revenue, the economy and jobs.

Ernst & Young (EY) conducted a full macroeconomic study on behalf of The Council of Insurance Agents & Brokers and the American Benefits Council to evaluate the impacts of such changes. Scan or click the QR code to read it now.

At the time of this report's publication, many provisions of the 2017 Tax Cuts and Jobs Act — including the ESI Tax Exclusion — are set to expire at the end of 2025. Dialogue around elimination and limits on the employer tax breaks for health insurance — and the economic reverberations of such a change — is ongoing.

Employee Retirement Income Security Act of 1974 (ERISA): This federal law protects retirement and health plans for private sector employees. ERISA requires fiduciaries to act in the interest of plan participants and beneficiaries, avoid conflicts of interest and follow plan documents.

Consolidated Appropriations Act (CAA) of 2021: Passed in December 2020, this Act includes provisions related to healthcare, employee benefits and taxes. It also reaffirms that employers are fiduciaries responsible for managing healthcare costs, allows them to remove gag clauses from service provider contracts, mandates more transparency in healthcare and establishes consumer protections from surprise billing.

- **Section 201:** The Gag Clause Prohibition Compliance Attestation (GCPCA) mandates certain plans and issuers submit an annual attestation of compliance to the Department of Health & Human Services, Department of Labor and the U.S. Treasury.
- **Section 202:** Brokers, agents and consultants must disclose cash and non-cash compensation related to group health insurance.
- **Section 204:** Prescription Drug and Health Care Spending Data Collection (RxDC) mandates the reporting of prescription drug and health-related spending from insurers and employer health plans to federal agencies.

Transparency in Coverage Rule (2020): Payers and providers must publish machine-readable files showing all contracted rates and make previously proprietary information public.

ERISA: Federally Mandated Fiduciary Duties

Recent legal cases and continued regulatory changes underscore the importance of transparency and ethical practices among brokers, service providers and all individuals responsible for implementing and managing employer-sponsored plans.

Companies and individuals are legally required to disclose data, fees and costs. Regulatory changes around transparency, high-stakes lawsuits and increased scrutiny around fees for providers, brokers and service providers illustrate the importance of fiduciary responsibilities for health plan sponsors. We will explore ERISA and fiduciary duties in more detail throughout the report, specifically within the High-Level Market Outlook section.

State-by-State Legislation

ERISA governs self-funded health plans and preempts state regulations related to health insurance. However, the uptick of state laws impacting service providers and PBMs that support all types of employer-sponsored health plans is an emerging trend.

While state-by-state legislation is intended to affect and protect constituents, the resulting legal nuances will likely drive further confusion — especially for employers running multi-state operations. State-specific laws affecting employer-sponsored health plans at the time of this report include Kentucky, Florida, Tennessee, Texas and Arkansas. Other states may follow.

Elimination of Gag Clauses

While the CAA itself is more than 2,100 pages in length, sections relevant to insurance and healthcare reference "increasing transparency by removing gag clauses on price and quality information" as well as "to have sufficient information reflecting allowed amounts paid to a healthcare provider or facility for relevant services furnished in the applicable geographic region." In simpler terms, the Act intends to provide visibility into claims data and ensure disclosure of all healthcare-related expenditures. The intent is to reduce fraud, waste and abuse in the healthcare system, ultimately benefiting all stakeholders.

Despite federal legislation requiring transparent sharing of relevant data, scare tactics and elaborate reasons for withholding information under the veil of "policy" or "Protected Health Information (PHI) concerns" are pervasive across the industry. In January 2024, the U.S. Departments of Labor and Health & Human Services issued clarification related to downstream agreements between third-party administrators (TPAs) and other entities, prohibiting provisions that indirectly impose gag clauses. Health plans and issuers must attest to compliance with the gag clause prohibition annually.

Stealth Pro Tip

To manage healthcare costs effectively and fulfill their fiduciary duty, employers must request and receive comprehensive, machine-readable data without restrictions. Requesting data that the carrier adjudicates, denies or qualifies on any member under the plan without restriction or limitation is a reasonable request.

High-Level Market Outlook

Self-Funded Market Overview

Fully-insured groups that are frustrated with the limitations of existing plans or unable to weather consistent double-digit rate increases are naturally attracted to self-funding and alternative risk offerings such as group captives. Lack of claims data leaves fully-insured groups in the dark, unable to address the drivers of high-cost claims and related impacts to their plans. Controlling the costs of a fully-insured plan can only be achieved by reducing benefits, shifting costs to the employee or changing carriers.

According to the Kaiser Family Foundation's (KFF) 2024 Employer Health Benefits Survey, 63% of U.S. workers are enrolled in a self-funded plan. Of the employers covering 1,000 to 4,999 and 5,000+ workers, 83% and 84%, respectively, opt for a self-funding structure. Unsurprisingly, most self-funded organizations are larger, but the percentage of self-funded groups with 3 to 199 workers rose slightly to hit 20%. The rate of self-funded groups employing 200 to 999 workers remained steady at 61% again for this reporting cycle.[3]

Of the self-funded plans covering 200 to 4,999 lives, 91.5% had secured stop loss insurance. For larger groups (5,000 lives or more), stop loss coverage in 2024 stood at 66%, a 6% increase over 2023. The uptick is likely due to the general rise in $1M+ claims, as larger groups weigh the cost of stop loss coverage with the financial risk of such catastrophic claims.[3]

Stop Loss Market Trends and Dynamics

While some carriers grew market share in a highly competitive, price-driven environment, a handful of large stop loss carriers have openly signaled lackluster earnings and escalating loss ratios despite a robust book of business and pragmatic approach to underwriting. Whether in press releases, interviews or public-facing earnings reports, the messages align in readying the stop loss market for rising rates. Larger carriers have floated the idea of tiered increases over time; others may adopt that strategy.

The primary trends affecting the stop loss market today include the continued increase in medical costs, a shifting payer mix, and the direct impact on carrier loss ratios. As the health industry grapples with growing Medicare and Medicaid populations, the lower government reimbursement rates must be offset by negotiating higher rates from commercial payers. Anticipated rate increases will drive higher costs for employers and influence the overall insurance landscape. The shifting payer mix and related impacts on employer-sponsored plans are covered in more depth within the Benchmarking Data section of this report.

Signs of a Growing — but Tightening — Market

According to Milliman's "Observations on the employer stop loss market"[4] report, the U.S. stop loss market reached $35.4B in annual premiums — a notable rise from the $31B noted in 2023 — with 68% of total premium derived from organizations covering between 251 and 5,000 lives.

Despite the estimated 12% year-over-year growth in the stop loss market, major carriers publicly reported lower-than-anticipated profits last year, with some sharing comments on projected profitability shortfalls well in advance. Others were less forthcoming, only recently aligning with the broader industry story about the severity of high-dollar claims paired with the healthcare system's escalating costs to provide quality care.

Although the stop loss market may appear stressed, it remains an attractive option for investors and private equity (PE) firms aiming to drive more aggressive, atypical returns.

Of the publicly available brokering M&A activity from 2024, a handful of sizeable deals ranged from just over a quarter billion to $13.5B. Granular Insurance Company, a stop loss subsidiary of Verily, was sold to Elevance Health. Unum Group's decision to shutter its stop loss operations and sell renewal rights to Amynta Group demonstrates the escalating market shift trend.

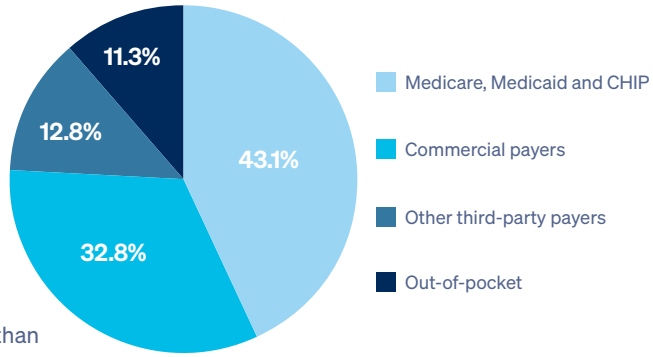
Opinions differ on whether a hard market is coming or if it is already here. It may be easier to recognize a hard market once it has come and gone rather than identify it while all parties actively navigate the cycle. Some experts predict significant rate increases will fully materialize by 2026, impacting renewals at that time. Others classify the pricing shift as becoming more rational and reasonable — citing a shrinking delta and necessary level-setting after the past few years of exceptionally competitive, aggressive pricing activity.

As the stop loss market continues to respond, adjust, innovate and normalize, indicators of imminent rate increases are impossible to ignore. Brokers can help clients by focusing on the overall value of a plan and its relevance to specific employee populations — especially if a plan integrates thoughtful cost controls and outside-the-box value.

Soft Market	Market Correction	Hard Market
Carrier Objective Maintain Underwriting Discipline in a Competitive Market	Market Adjusts to Restore Pricing Balance	**Carrier Objective** Drive Rate and Grow Market Share when Market Capacity is Reduced
Characteristics		
New Carrier Entrants		Decreased Capacity
Increased Capacity	⟷	Stringent Underwriting
Favorable Underwriting		Reduced Coverage
Competitive Pricing		Pricing Implications

▶ In Action:

Based on the most recently accessible data* from 2023, Medicare, Medicaid and Children's Health Insurance Program (CHIP) comprised 43.1% of the patient population and drove $1,926.16B in healthcare spending. Commercial payers represented 32.8% of the patient population and accounted for $1,464.6B in expenditures.



According to a RAND** Hospital Price Transparency Study released in May of 2024, private payers spent between 188% and 254% more than Medicare beneficiaries for the same services at the same facilities in 2022.

The notably lower reimbursement rates for the Medicare, Medicaid and CHIP population have further exacerbated the pressure on the healthcare system and are impacting the commercial market. Additionally, the influx of managing general underwriters (MGUs) and resulting competitive pricing strategies have likely skewed client expectations regarding rates and cost. More established businesses remain less likely to compete on rates alone.

* U.S. Department of Health and Human Services (HHS) National Health Expenditure Accounts (NHEA). ** RAND is a research organization focused on exploring public policy challenges.

Pharmacy Landscape

Infusions, Biosimilars, Specialty and Generic Drugs

Specialty medications and novel therapies, while incredible and lifesaving, impose extreme costs on health plans. Not long ago, a plan could anticipate a 10% to 15% prescription drug spend. Today pharmacy costs can consume 30% or more of plan resources. Infusions — often critical and sometimes the only available treatment for specific conditions — are a notable driver of higher premiums and financially burdensome for 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 is driving the majority of a plan's costs, personalized care, guidance and clinical oversight are paramount and possible.

The expanding biosimilar market represents a significant shift in drug pricing and accessibility, making adoption strategies a key focus for healthcare stakeholders. The FDA approved several biosimilars (generic biologics) in 2024 and early 2025, including multiple alternatives for Stelara, Actemra and Prolia/Xgeva. More than 25 biosimilars are in the pipeline at the time of this report. Biosimilar alternatives could reduce costs by up to 80% compared to current brand-name versions.

Traditional generic drugs are another lower-cost alternative to brand-name medications — but bringing generics to market takes time. Most branded drugs are protected from duplication by a competitor under a 20-year patent. Additional protection (granted by the FDA) provides exclusive marketing rights for a specific period after a drug's approval.

Generic drugs are identical to brand-name drugs in chemical composition but need not undergo the same rigorous research, development and testing process to determine safety, efficacy or dosage levels. Generally, generic drugs may cost up to 95% less than the original brands. According to the FDA, generic drugs account for more than 90% of retail prescriptions.

> ▶ **In Action:**
> Journavx, a new non-opioid oral tablet to treat moderate to severe acute pain, earned FDA approval in January 2025 and was noted as "an important public health milestone" in an effort to continue to approve "safe and effective alternatives" to opioids for pain management. A single 50mg pill of Journavx costs $15.50, and a generic, non-branded opioid pain pill averages $0.50.

Site of care 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.

GLP-1s and Injectables

Conversations around cost, coverage, efficacy and use of GLP-1s for a variety of diagnoses are ongoing. A 2025 JAMA Network study found that 46.5% of patients with type 2 diabetes and 64.8% without discontinued GLP-1 use within one year.

Patients most commonly stop using GLP-1s due to "inadequate blood glucose control," and 43.8% discontinue use due to unpleasant gastrointestinal symptoms (nausea, constipation, etc.) and even pancreatitis, bowel obstruction and gallstones.

Despite the risks, widespread consumer interest in GLP-1s for weight loss has not waned. Limiting coverage to diabetes and other medical conditions should be confirmed with a provider's clinical documentation and chart notes to limit unintended use for weight loss.

Last year's large-scale shortages of semaglutide and tirzepatide injection products (such as Wegovy and Zepbound) opened the doors for compounded versions of both drugs to hit the market. Compounded GLP-1s are made in an FDA-approved facility but are not FDA-approved. However, compounded injectables have gained popularity as a cash-pay alternative for individuals whose insurance does not cover these drugs. Semaglutide and tirzepatide were both removed from the FDA's drug shortage list in early 2025 and late 2024, respectively. The FDA ordered distributors and pharmacies to discontinue sales of compounded GLP-1s by early spring; however, pending litigation may result in an extension of this timeframe.

▶ In Action: Scaling Back Coverage for Weight Loss Drugs

In January 2024, the North Carolina State Health Plan Board of Trustees announced that GLP1-s would no longer be covered for obesity as of April 1, 2024. The expected $170M in cost that the drugs would add to the budget was a major factor in the decision. In 2025, the Health Plan requested an additional $100M to allow coverage for members with a body mass index (BMI) of 38 or greater. Requiring participants to meet specific health-related criteria in order to access GLP-1s will likely save the group in total cost but may make the group ineligible for rebates.

GLP-1 usage may delay or prevent high-dollar chronic health conditions down the line, but the risks, benefits and potential cost implications remain unclear. Some experts suggest GLP-1s can help a member shed additional weight, alleviate long-term, chronic stress on hips, knees and hearts and possibly prevent elective surgeries.

On the other hand, GLP-1-related side effects and adverse events — such as gastrointestinal complications and hospitalizations — or future elective surgical costs may offset or even negate any near-term savings. While the upward trend of GLP-1 use has not materially impacted stop loss, it is affecting aggregate per member per month (PMPM).

Health Systems and Network Contract Disputes

While not highlighted in last year's report, our experts note an increase in strained regionally-based health system and network contract discussions. Insurers and providers are engaged in challenging negotiations driven by significant cost increases. Rising labor costs are a primary driver, with many hospital systems still struggling to regain profitability following the Pandemic.

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 considering the shifting payer mix and increasing utilization of high-cost specialty drugs. Providers are raising base costs to maintain existing discount structures or reducing the discounts offered to insurers to offset financial pressures. No matter the tactic, the increasing costs are problematic for insurers.

Network disputes are an emerging trend; however, the pain of delayed and derailed negotiations has sporadically impacted brokers and employer groups thus far. Bubbling pricing pressures will surface as contracts are set for renewal – regardless of location.

▶ In Action: Providence Health & Services Dropped from Aetna Network in Oregon[5]

Following a breakdown in negotiations between Providence Health & Services and Aetna, the contract expired on December 31, 2024. While both sides blamed the other for the impasse — Aetna citing Providence's "unreasonable rate increases" and Providence accusing Aetna of failing to "step up" and shoulder its share of rising health care costs — approximately 9,000 Aetna-insured patients were left stranded in the wake. Some Providence clinics in southern Oregon (operating under a separate Aetna contract) remained in-network until mid-February, causing further confusion among covered members.

Further exacerbating the issues, an early January nurses' strike within the Providence system resulted in a 20% to 42% wage increase over the contract's three-year duration and an immediate pay bump between 16% to 22%. Health system labor costs will continue to compound negotiation pressures.

ERISA Implications for Health Insurance Fiduciaries

Retirement plan-related fiduciary responsibility under ERISA is widely understood and accepted in the financial industry, but ERISA also governs fiduciary duties in the health and welfare space. In last year's report, the *Johnson & Johnson vs. Lewandowski* case was earmarked as litigation to watch. In January 2025, the United States District Court for the District of New Jersey determined that the ERISA fiduciary breach claims in the case were unfounded because the plaintiff could not prove specific damages to the individual.

Although the outcome was not what many experts expected — and neither was the recently dismissed *Navarro v. Wells Fargo & Company* case — the decisions provided detailed insight for the next plaintiff alleging a failure of plan sponsors to monitor PBM contracts proactively.

Fiduciaries managing 401Ks and pensions are no strangers to transparency, clarity, negotiated fees and prudent oversight of plan-related decisions. ERISA dictates the same diligence and process-oriented approach must also apply to employer-sponsored health plans.

While the focus related to ERISA in the insurance sector has been driven by the possibilities of litigation or steep fines, at its core, ERISA is not centered on punitive intent. ERISA dictates the necessity of a formal, fiduciary process that includes appropriate documentation and enables prudent decision-making that serves the best interests of plan participants.

Stealth Pro Tip

ERISA mandates due diligence and a prudent, documented decision-making process; however, ERISA is not specifically about the outcome. Focus on where plan expenses go — and why — and leverage data to determine the best possible plan structure for the individual group. Educate clients about ERISA compliance and check in frequently — especially if clients are slow to integrate appropriate plan oversight and controls.

▶ In Action:

In March 2025, current and former participants in JPMorgan Chase's employee health insurance plan filed a lawsuit against the company, its bank, company executives and members of the board's compensation and management development committee. The case — *Seth Stern et al. v. JPMorgan Chase & Co. et al.* — was filed in the U.S. District Court for the Southern District of New York.

Plaintiffs claim the defendants breached their fiduciary duties under ERISA by allowing the plan to pay grossly inflated prescription drug prices, resulting in millions of dollars in excess costs for participants through higher premiums, deductibles, copays and suppressed wages. The complaint states that the Plan overpaid its pharmacy benefits manager, CVS Caremark, for generic drugs that were widely available for far less.

This case cites inflated prices for all 366 generic drugs in the Plan's formulary, a different approach from the J&J and Wells Fargo lawsuits in which only some of the prescription drugs in the formulary were mentioned. Plaintiffs in this case highlight a $6,229 charge for a 30-unit supply of teriflunomide — available at retail and online pharmacies for less than $33 — and the Plan's single biosimilar option for Humira, which was still more than double the cost of other options. This complaint also goes beyond the previously mentioned cases by alleging that plan fiduciaries violated their duty to make decisions for the exclusive benefit of plan participants by allowing outside business factors to influence their judgment.

The plaintiffs seek damages, class-action status, restitution of losses, appointment of an independent fiduciary and replacement of the PBM.

Strategic Stop Loss Procurement and Renewals

Carriers monitor inflation and profitability closely — continually evaluating cost, group risk and delivered value. While it is essential to consider shopping stop loss coverage annually and rates will always be a significant factor in any fiduciary's decision-making process, price should not be the sole consideration. The carrier's quality and contract provisions are equally important. A knowledgeable broker can help navigate these complexities by offering creative cost-containment solutions, suggesting cost-saving programs or audits and leveraging niche expertise to build robust employee health plans.

Lasers and Strategy

In 2025, 29% of Stealth's groups had at least one lasered individual — a slight increase compared to prior years. Previously, larger groups tended to have fewer lasers relative to smaller groups, but in 2025, more groups with over 1,000 lives added lasers to their policies.

	Groups with Laser Present*		
Group Size	**2023**	**2024**	**2025**
0-100	29%	26%	29%
100-250	30%	30%	34%
250-500	31%	26%	27%
500-1,000	28%	26%	27%
1,000-1,500	23%	19%	33%
1,500-2,000	12%	20%	22%
2,000-5,000	17%	19%	27%
5,000+	15%	20%	21%
Total (Average)	**28%**	**26%**	**29%**

While it is advisable to opt for a No New Laser/Rate Cap (NNL/RC), in some instances, taking a laser in lieu of a known risk built into premium may be financially advantageous for funding a high-cost claim. Despite the up-front costs of purchasing NNL/RCs, the benefit of risk transfer and/or avoidance often proves financially beneficial.

	Groups with NNL/RC Provision*		
Group Size	**2023**	**2024**	**2025**
0-100	45%	44%	43%
100-250	65%	64%	71%
250-500	73%	76%	80%
500-1,000	74%	76%	80%
1,000-1,500	71%	79%	83%
1,500-2,000	78%	77%	82%
2,000-5,000	79%	79%	82%
5,000+	76%	76%	86%
Total (Average)	**68%**	**69%**	**73%**

Key Takeaways

The current percentages are fairly consistent regardless of group size. Given that larger groups typically select higher deductibles to start, opting to add lasers is one way to mitigate increases on stop loss rates. This trend may be driven by the fact that groups are electing additional protections, like NNL/RC policies. General awareness of shock claims and catastrophic risk is likely driving interest in NNL/RC provisions across all group sizes. It is more difficult for smaller groups to secure NNL/RC protection.

* Data Source: Stealth's book of business as of Q1 2025

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 2024 would cost **$173,600*** in 2025.* Stop loss carrier's liability went up by **22.6%**.

This is called **leveraged trend**.

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

Understand the Spectrum of Cost Containment Strategies

Consider options tailored to specific groups, such as unbundling stop loss and exploring narrow networks, RBP, Direct Primary Care and condition-specific protections for cell and gene therapies, dialysis and organ transplants. Transparent PBM contracts, pass-through pricing, rebates, utilization management, and alternatives like generics and biosimilars can help address rising prescription drug costs. Specialty drug expenses can be managed through international pharmacies, 340B and infusion carve-outs.

Brokers should not rush to change multiple plan components all at once, but adopting even one cost-saving strategy this year could make a significant impact.

Confirm Dependent Eligibility with Audits

Thorough and consistent dependent eligibility audits are critical for protecting the plan and its members from unnecessary stress, chaos and risk. A robust, technology-driven verification process can eliminate the burden of manual validation and proactively identify ineligible individuals. Employers can deploy audits via mobile apps, websites or even paper forms. Providing multiple methods for employees to answer all questions removes a barrier to completion.

Employers are not always privy to employee life events such as divorce or child custody changes, and an individual's understanding of his/her common law marriage or domestic partnership can be vastly different from a plan's definition of "marriage" and "spouse."

Without an eligibility audit process, discrepancies typically come to light after a claim is in process, causing extreme frustration for beneficiaries and the employer.

Stealth Pro Tip

Deploying an audit is a sensible, actionable strategy to protect plan assets from intentional or unintentional waste or misuse. Brokers can reference Stealth's high-level eligibility guide to address common definitions and learn more about eligibility best practices.

Amwins' audits reveal that 3% to 6% of dependents are ineligible for the benefits programs they are enrolled in. On average, $5,000 per dependent per year is saved when ineligible individuals no longer impact the plan.

▶ In Action:

A dependent eligibility audit of 6,700 covered dependents in Florida revealed 288 ineligible individuals, representing 4.3% of the total plan. The client achieved an estimated savings of $1.3M** by removing ineligible dependents. Along with generating a 28x return on investment (ROI) from the audit, the Coordination of Benefits (COB) data indicated that a spousal surcharge could be considered as a possible cost management approach.

** Calculation based on the client's average cost of $4,500 per dependent x 288 ineligible individuals removed from the plan.

Fully-Insured Transition Strategies

Economic factors, year-over-year rate increases and lack of negotiating power are cultivating an ideal environment for fully-insured groups to explore self-funding and other alternative risk strategies. In the U.S., while 65% of workers are already enrolled in a self-funded plan, the remaining 35% may be open to greater control, flexibility, savings and transparency related to healthcare spending. Per McKinsey research, the fully-insured commercial market lost 2.9M members from 2021 to 2023. By 2030, anywhere from 4M and up to 14M more members could shift away from fully-insured plans.[1]

Artificial Intelligence (AI) also enables carriers to better evaluate and underwrite fully-insured groups without claims experience by pulling de-identified historical medical and prescription drug data at the member level. With predictive analytics to help forecast future claims and trends, stop loss carriers gain insights into a group's risk profile and can confidently offer a competitive rate for the anticipated risk.

Stealth Pro Tip

Building a multi-year strategy for cost-containment — rather than trying to tackle everything in year one — is recommended. Balancing member disruption is also a good idea. For example, implementing an RBP strategy could generate significant savings, but a rushed execution can frustrate members. Proper stop loss terms and conditions and a comprehensive plan document review should be in place to ensure a successful transition.

Brokers must understand the pros and cons of available transition options — primarily level-funding, captives and traditional self-funding — to help clients evaluate the various structures and pathways toward self-funding. They can then align expectations and identify the right administrator, network, pharmacy vendor, key plan elements and partners. An employer's appetite for risk, group size and access to claims data will heavily influence such decisions.

Employer Stop Loss Captives

The swell of interest in captives, especially over the past year, is a notable trend. EY's 2024 Global Insurance Outlook Report highlights the "relentless" growth of captives — also commonly referred to as alternative risk — now represents nearly 25% of the overall commercial insurance market with $176B in global premiums written through captives.[6] Stealth's experts estimate that captives currently represent up to 10% of the stop loss market.

In a captive arrangement, like-minded companies pool their claims risk to reduce the cost of their collective benefit spend. The captive's owner assumes a level of risk — similar to an insurance company — but under streamlined regulatory requirements. Well-structured captives leverage the stability and cash flow protection of stop loss solutions while helping to offset catastrophic claims risk. By forming or joining a captive insurance company and following the law of large numbers, plan sponsors gain purchasing power, lower administrative fees and yield more predictable outcomes while diversifying risk exposure.

Captives can be a competitive alternative to commercial markets and may produce material returns for their owners. Employers are drawn to captives to avoid the across-the-board rate impacts felt in hard markets, and brokers and carriers view captives as a significant, trending growth opportunity. Captives hold particular allure for private equity-owned companies that must closely monitor risk and cost while strategically investing finite resources into employee health.

Relative to fully-insured structures, captives provide materially increased transparency, including detailed claims data and analytics, and employ a greater variety of cost controls. A captive can become a profit center and provide potential tax benefits for participating employers.

Captives are complex and require more time and attention to build. However, the right partner can provide invaluable perspective and deliver an effective, functional and transparent structure. In many cases, the additional effort pays off through cost savings and favorable returns and it is common for companies to remain in their captives long-term.

Pure or single parent captives are owned by the policy holder, a larger or private company aiming to insure its own risk. Insuring multiple types of risks within this type of captive is common. Depending on the size and risk tolerance of the owner, stop loss and reinsurance may be deployed in various forms. **Group captives** are owned by multiple policy holders and are most common for mid-market groups. In this structure, like-minded companies operating within the same industry or with comparable employee numbers can pool risk. **Agency captives** are driven by third parties offering unique benefits to a niche market. Although not owned by policy holders, distributions for good performance can be a draw for employer groups. Agency captives are becoming more common in the group benefits space.

Level Funding

Level funding has grown dramatically in the past few years, especially for small businesses and employers covering less than 200 lives. In 2024, 36% percent of covered workers in small firms (3 to 199 workers) were in a level funded plan, compared to a mere 6% in 2018.[2]

Some experts partially attribute the growth of level funding structures to the Affordable Care Act (ACA) and its affordability mandates, essential benefit requirements and community rating rules. While well-intended, the increased costs for fully-insured groups drove many toward alternative options — like level funding — to offer comprehensive health coverage to employees but at a lower price.

Level funded health plans mimic the feel of a fully-insured arrangement while also realizing some of the benefits of self-funding. These plans are considered a type of self-funding, so they are not subject to state-mandated coverage laws. They are also generally exempt from state premium and ACA health insurance taxes.

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.

While level funding may be a strategy to exit the fully-insured space, it is not as flexible as a traditional self-funded arrangement. Plan design options, vendor choice, reporting and pharmacy rebates are often limited. Brokers must understand the pros and cons of all structures and consider eventually guiding level funded clients to a traditional self-funded program.

Cash-Flow Considerations

Potential cash flow impacts are dependent on a plan's structure and provisions. Even with the benefits and financial protections of self-funding, the timing of a high-cost stop loss claim reimbursement is a significant consideration. Groups must have a plan to manage cash outflow and inflow — and any resulting business impacts — during that critical period.

Reimbursement for a clean stop loss claim should average between 10 to 15 days. Specific Advance — a provision created by stop loss carriers to address cash flow concerns — often works as it should but is not fail-proof.

A Third Party Administrator (TPA) can typically pend a claim for 30 days before they risk losing the network discount. Any delay in the reimbursement process (due to missing claims data, eligibility discrepancies or an audit) forces the TPA to pull funds before the stop loss reimbursement has gone through.

BUCA-administered plans cannot hold claims for Specific Advance and funds are pulled almost immediately. However, most BUCAs do not require the client to fund the register for up to 48 hours after the claim occurs.

Stealth Pro Tip

To help alleviate cash flow challenges in both TPA- and BUCA-administered plans, Stealth Advance will fund claims up to $5M within 24 to 72 hours of a loss. Stealth 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.

High-Cost Claims Conditions

Widely referenced industry sources and reports showcase specific high-cost claims conditions and stop loss trends each year. Ranking differs from carrier to 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 2023 claimant data from several of our largest carrier partners, the most frequent high-cost condition categories included:

High-Cost Claims Conditions (by Frequency)	Claim Frequency per 10K Employees	Average First $ Claim Size	Stealth Rank*
Malignant Neoplasms	13.8	$360K	1
Diseases of the Circulatory System; Cardiovascular	3.8	$330K	2
Injury and Poisoning	2.2	$470K	7
Diseases of the Digestive System	2.2	$270K	4
Endocrine and Metabolic Diseases	2.0	$350K	8
Diseases of the Genitourinary System (Urinary and Renal)	2.0	$250K	5
Diseases of the Nervous System	1.8	$310K	6
Diseases of the Musculoskeletal System	1.7	$230K	3

* Stealth rank based on stop loss claims paid for the 12 months starting November 2023 through October 2024; most frequent primary diagnosis of large claimants.

Consistent with other leading stop loss carriers, the top three health conditions responsible for $1M+ claims across Stealth's book of business** include:

High-Cost Claims Conditions (over $1M)	Stealth Rank**
Malignant Neoplasms	1
Newborn/Infant Care; Certain Conditions Originating in the Perinatal Period	2
Diseases of the Circulatory System; Cardiovascular	3

** Based on Stealth's 2023 high-cost claimant data.

Malignant neoplasms were most frequently associated with high-cost claims and claims over $1M. This disease state accounted for nearly 30% of Stealth's $1M+ claims.**

Despite not ranking among the top eight high-cost conditions in terms of frequency, perinatal and newborn-related claims are the second most common drivers of $1M+ claims.

Preterm birth rates in the U.S. have increased over the past decade, and one in every 10 babies is born before 37 weeks.

In vitro fertilization (IVF) and intrauterine insemination (IUI) treatments are associated with an increased risk of preterm birth. However, employer-provided fertility benefits are highly valued by employees seeking medical support to build their families. Racial, ethnic and socioeconomic factors — and the health and lifestyle of the pregnant mother — may also influence the likelihood of a preterm birth. The exact reasons remain unclear, making newborn claims tougher to predict.

Site of Care Pricing Differentials for Injectable Prescription Drugs and Infusions

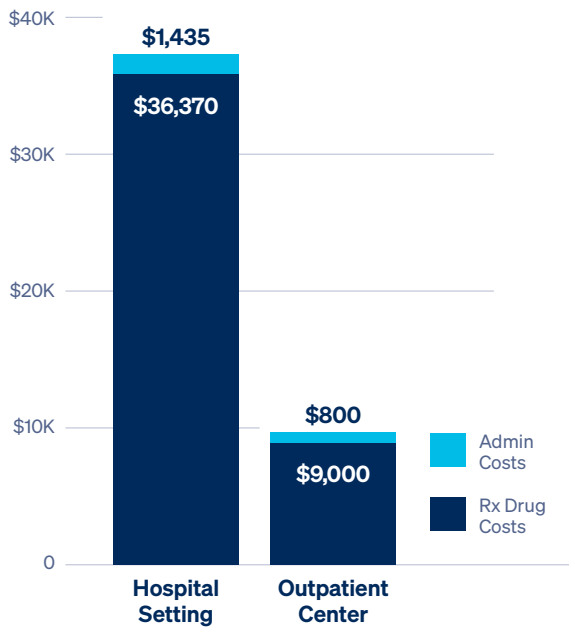
While hospitals serve a critical purpose in communities, most healthcare experiences — and especially infusions — need not occur in an acute care setting. A 2024 Berkley Public Health study[7] found that hospitals eligible for federally mandated discounts charge insurers 300% more than the cost paid for infusion drugs, and hospitals ineligible for federal discounts imposed an average markup of 240%.

Infusions given at an outpatient clinic, ambulatory care center or in-home will deliver extreme cost savings for health plans, and increasingly so over the long term.

▶ In Action:

In the example below, the costs to administer the same specialty infusion to treat cancer at a three-week cadence in two different facilities reveal startling variances.

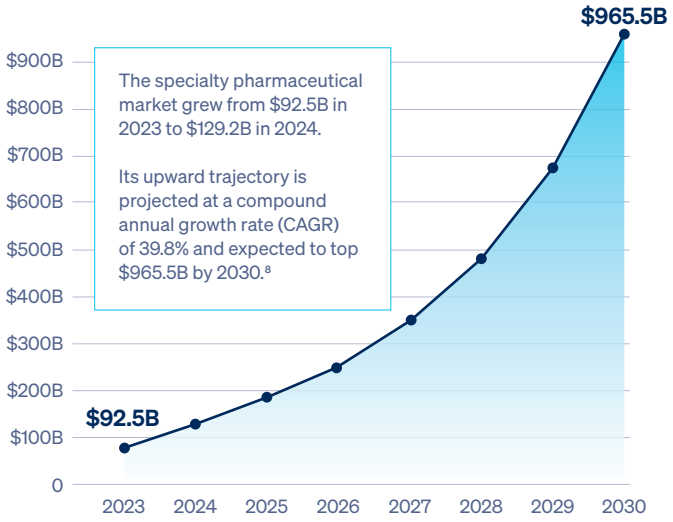
Administering the infusion at an outpatient center instead of a hospital setting saved $28,006 per treatment and $485,438 per policy period.



* Tier 1 countries are considered to have strong pharmaceutical regulations and oversight, ensuring that drugs produced and exported from these locations meet high quality standards. According to the FDA, Tier 1 countries include: Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, the European Union or a country in the European Economic Area (the countries in the European Union and the European Free Trade Association).

Projected Growth of the Specialty Pharmaceutical Market

Historical and forecasted data illustrate an aggressive growth pattern in the specialty pharmaceutical market within a condensed window of time. Such a dynamic shift will certainly impact employers and related stop loss claims activity.



Transparent PBMs, Specialty Pharmacies and Rebates

Employer groups are becoming more open to patient-focused, clinical PBMs as alternatives to the top three — CVS Caremark, Express Scripts, Inc. and OptumRx, Inc. All of the top three PBMs offer a variation of the cost-based reimbursement model.

Some transparent PBMs deploy a simple administrative fee, others cap shared savings, and some pass total rebate dollars directly to clients. Many clinical PBMs lean into a patient-advocacy role, with robust teams of on-staff pharmacists to help ensure patients are on appropriate medications and offer education about site of care options for high-cost infusions and surgeries.

In response to rising prescription medical costs, interest in international sourcing is also heating up. Along with the convenience of direct-to-home shipping, international prescription drug sourcing from Tier 1 countries* allows patients to access brand-name medications (in sealed, original manufacturer packaging) at significantly lower costs. International import of FDA-approved drugs for personal use is illegal in most circumstances, but several state-specific laws permit import programs.

Specialty carve-out programs, explored in more detail on the following page, are common strategies to manage plan costs and risk.

Cost-Containment Solutions

Cost-containment offerings have multiplied rapidly in recent years, and the ability to make shared decisions improves almost daily. No matter how well a population base or geographic market is understood, no one can perfectly predict a premature baby (or babies), septicemia or cancer diagnosis.

Dialysis Management Solutions

Kidney disease and related long-term medical expenses can wreak havoc on a health plan. An estimated 15% of adults in the U.S. (37M+ people) are living with some level of chronic kidney disease, and more than 800,000 people are coping with end-stage renal disease (ESRD). With more than 100,000 new ESRD diagnoses annually, the demand for dialysis will continue to grow.

The financial impacts of outpatient kidney care on employer-sponsored plans are severe. With minimal competition among for-profit dialysis providers and a three-year runway of private insurance reimbursement rates before a dialysis patient moves to Medicare coverage, facilities are eager to squeeze as much profit as possible from commercial payers for as long as possible.

Within a strong dialysis management program, at-risk members are identified and paired with a knowledgeable case manager to explore possible early interventions. Once a member begins dialysis, robust repricing coupled with case management can reduce costs up to 85% or more on billed charges, including all program fees and costs.

Organ Transplant Carve-Outs

The high cost of an organ transplant begins accruing long before the surgery itself, and costs vary widely depending on the type of transplant and the location where care is delivered. Carving transplant risk out of the plan as timing allows is a proactive approach to controlling pre- to post-transplant costs. Carve-out programs can also steer potential beneficiaries to right-venue, high-quality care facilities (COEs) and provide additional credits for travel and other surgery-related considerations. Organ transplant programs are likely to reduce stop loss premiums and eliminate lasers, while proactively isolating and managing notable financial risk. Most organ transplant policies have a 12-month preexisting condition provision, although stop loss would provide coverage through this period.

Diabetes Prevention and Education

Diabetes is the most expensive chronic condition in the country, impacting almost 40M people and generating more than $413B in annual medical costs. One in every four dollars spent on healthcare is attributed to diabetes-related services. Hospitalizations, complications, medications and doctors' visits — and indirect costs such as lost productivity, disability and early mortality — are just a few factors tied to the financial burden of this chronic disease. High-cost conditions such as heart and kidney disease and strokes are commonly diagnosed in individuals living with diabetes.

Despite the rise in diabetes prevalence, solutions such as mobile apps, medically trained care managers and nutritionists can be deployed to focus on prevention and management. A plan to integrate GLP-1s along with lifestyle modifications may also be a clinically appropriate option. Whether it be through counseling to uncover health barriers or educational resources to support behavior change, actively engaging employees with personalized support can help manage and control an anticipated diabetes diagnosis.

Premature Birth Prevention and Neonatal Care

Claims related to the perinatal period include premature infants with complications and micro-premies who spend days, weeks or months in a neonatal intensive care unit (NICU).

A perinatal stop loss claim may seem unavoidable, but specialized vendors can offer guidance and support to help contain as much of the cost as possible. Outsourcing maternity healthcare management to a specialized vendor or provider can improve care coordination and potentially prevent pre-term births. Following a baby's birth, a third-party NICU specialist can ensure that care is clinically appropriate and review claims documentation for coding errors. Specialized vendors also offer case management to actively address social determinants of health factors — such as food insecurity, transportation challenges and housing instability — that typically impact the health of infants and immediate family members.

Stop loss carriers may begin factoring in the costs of IVF and other fertility benefits in their ratings, given the increased risk of premature births, multiple births and higher neonatal care expenses.

Brokers are encouraged to tap into niche subject matter experts who are well-versed in condition-specific cost controls and innovative prevention programs.

Cell, Gene and CAR-T Therapies

Conversations around high-cost cell, gene and CAR-T therapies continue to evolve. Questions about fair market value — critical to incentivizing continued manufacturer research and innovation — durability, outcomes and efficacy pepper many spirited discussions about the topic. Despite the varied perspectives on innovative care for rare and very rare conditions, new cell, gene and CAR-T therapies are receiving FDA approvals at a faster cadence than years prior. The long-term impacts of novel therapies on commercial and government health plans are uncertain.

A well-structured strategy can address the great financial risk for plan sponsors and stop loss carriers. Some therapies now reach $4M+ — and possibly more for multi-use treatments. The wide variances in facility fees to administer such therapies, pharmacy markup and potential inpatient admissions for adverse reactions and costly hospitalizations, particularly for immune-compromised individuals, must be considered when building a plan and cost-containment strategy.

At the time of this report's release, 38 therapies — 23 cellular and 15 gene — had received FDA approval. Of the more than 4,000 cell and gene therapies in the approval pipeline, more than 200 are in late-phase development.

Not all therapies will make it to market. Still, between seven and 10 treatments are likely to earn approval before the end of 2025, including an additional gene therapy to treat hemophilia, a condition which impacts upwards of 33,000 people in the U.S.

One source expects 85 new gene therapy approvals by 2032 with an estimated 10-year list price spend of $35B to $40B.[8]

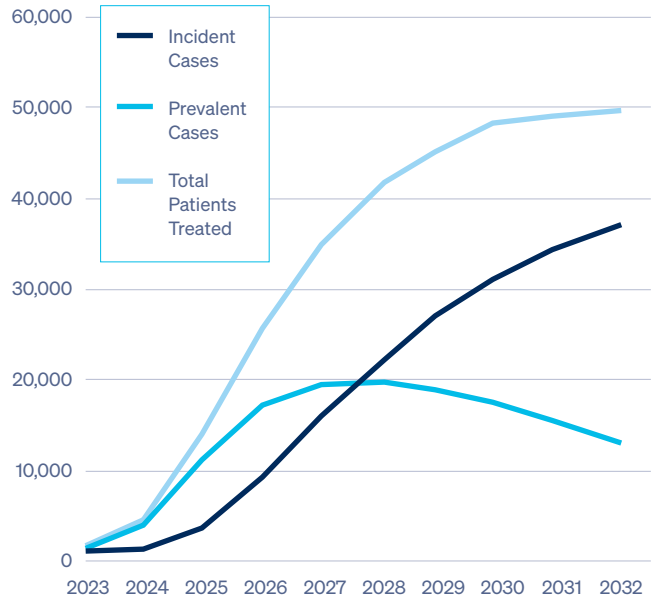
Notably:

- **Deramiocel** is a cell therapy to treat Duchenne muscular dystrophy (DMD) expected to receive FDA approval this summer. This therapy will be the first available treatment for DMD cardiomyopathy patients. Unlike Elevidys (a $3.2M gene therapy approved to treat DMD in 2023 with an expanded approval granted in 2024), Deramiocel is a multi-use treatment expected to alleviate concerns around the reproduction of skeletal muscle. This therapy would be administered quarterly with an expected price tag of $1.1M. It could be administered on its own or in conjunction with Elevidys.

- **Vyjuvek** is a multi-use, topical gel treatment for wounds in patients six months of age and older with dystrophic epidermolysis bullosa (DEB). The cost to administer Vyjuvek is estimated at $22M over a patient's lifetime.

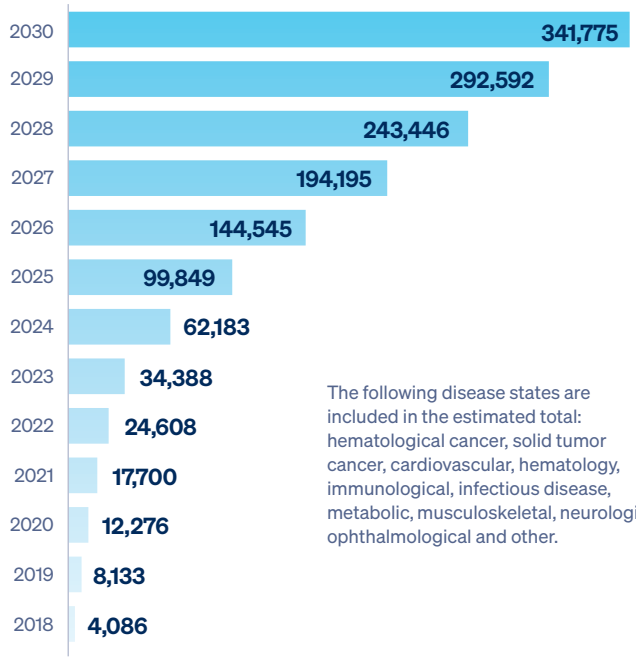
- **Zevaskyn** is a new cellular gene therapy approved by the FDA in late April 2025 to treat the recessive dystrophic form of epidermolysis bullosa (RDEB). Zevaskyn is expected to hit the market in the third quarter of 2025 with a wholesale price of $3.1M. This approval marks a new era of patients potentially utilizing more than one gene therapy treatment to manage their condition. Vyjuvek — also used to treat dystrophic epidermolysis bullosa — is viewed as a complementary approach.

Estimated Gene Therapy Treatable Patient Population by 2032



Data Source: Managing the Challenges of Paying for Gene Therapy: Strategies for Market Action and Policy Reform: Institute for Clinical and Economic Review and NEWDIGS, Tufts Center for Biomedical System Design (April 2024)

Number of Cumulative Treated Patients (Estimated Total)



The following disease states are included in the estimated total: hematological cancer, solid tumor cancer, cardiovascular, hematology, immunological, infectious disease, metabolic, musculoskeletal, neurological, ophthalmological and other.

Data Source: Center for Biomedical Innovation, Massachusetts Institute of Technology, Cambridge, MA: "Estimating the Clinical Pipeline of Cell and Gene Therapies and Their Potential Economic Impact on the US Healthcare System"

Considerations and Expected Utilization

The availability of innovative treatments — including recent approval for Elevidys to treat muscular dystrophy in adults — is evolving, and the expansion of novel therapies beyond rare and ultra-rare conditions is on the horizon.

Projected therapy approvals in 2026 will address more common conditions such as neovascular (wet) age-related macular degeneration — the most common cause of severe vision loss across the globe — knee osteoarthritis, prostate cancer and diabetic peripheral neuropathy.

Early diagnosis and detection of rare conditions like spinal muscular atrophy (SMA) may spur faster intervention with already-approved therapies. All 50 states incorporate SMA into newborn screening panels, and Zolgensma — with a $2.3M price tag —is the only gene therapy for this disease state. In Stealth's book of business, Zolgensma treatments are the most frequent cell and gene therapy claim.

High-cost cell and gene therapy claims — particularly in the absence of protective cost-containment programs — will strain the market and accelerate hardening conditions. While stop loss carriers have experienced a handful of significant cell and gene therapy claims across their blocks of business thus far, most report that the lower-than-anticipated frequency rates of such claims have kept related losses manageable.

Acknowledging the nuances of FDA labeling and evaluating potential incidence risk as labels expand to include a larger pool of patients can help guide plan sponsors to the right cost control programs. Initial FDA label approvals are typically limited to a smaller subset of the total prevalent population affected by a specific condition. Misalignment between clinical efficacy, regulatory approvals and patient desire — or even desperation — for the treatment further complicates coverage limitations and decisions. Decisions related to rare disease treatments must be clinically appropriate and, in the best cases, cost-effective for employers and patients.

▶ In Action:

Approximately 100,000 people in the U.S. live with sickle cell disease. Average lifetime medical costs can exceed $2M, with severe cases incurring between $4M and $6M across a lifespan. Two currently approved, one-time gene therapies for this disease state parallel the average lifetime medical cost of patients while alleviating years of ancillary strain on the impacted individuals, their families, the employer and the healthcare system.

Carrier Insights

This year, a group of well-recognized carriers — with blocks of business ranging from $544M to $2.7B of written premium — shared insights for this report. Overall, the rising tide of healthcare costs will impact both fully-insured and self-funded plans, but larger and more established carriers are well-positioned to manage industry changes. Carriers remain highly focused on leveraging data and encouraging cost-containment strategies.

While the stop loss market remains very competitive, some carriers are achieving higher rate increases while retaining desirable groups. Under the guidance of educated brokers — and with the integration of AI, creative plan strategies and innovative partners — groups are finding ways to maintain robust health coverage for employees despite inflationary pressures and rate increases.

Many carriers are optimistic about captives, citing the natural affinity of even the most risk-averse groups to proactively manage employee health and wellness when returns and incentives are directly tied to performance.

In general, each carrier has its own target appetite and risk philosophies — whether it be captives, reference-based pricing (RBP), small group, large group, industry-centric or geographically focused. Carrier strategies to transition fully-insured groups and gain new business are varied but prevalent.

Renewals and Growth

Competitive market dynamics, the necessary shedding of unprofitable groups and strategic pricing adjustments continue to shape the landscape. Most stop loss carriers report renewal premiums and case counts aligned with expectations — between 70% and 75% persistency.

Early underwriting locks are increasingly challenging due to more complex treatment plans and longer-tail billing processes; however, some carriers are offering early renewal incentives (lower rates) for desirable groups that renew within a condensed time window. To date, rate increases have not kept pace with medical inflation.

Optimizing Stop Loss Programs, Terms and Rates

Stop loss carriers certainly recognize the value of proactive plan management and shared savings models. Carriers are prioritizing groups that demonstrate a commitment to engaging employees and controlling costs — particularly with programs that demonstrate measurable savings. Such groups are likely eligible for additional discounts and more favorable rates and terms.

Employers leveraging payment integrity solutions — such as pre-payment claim audits — can prevent unnecessary claims expenses. Addressing major and minor errors consistently and over time can result in significant cost reductions for the plan and carriers. External vendors focused on payment integrity and claims review are demonstrating substantial savings and gaining traction by shining a light on systemic billing inconsistencies and errors that have unfortunately been widely accepted for decades.

Steerage techniques — including narrow networks and direct contracting — can incentivize members to engage with specific providers with lower deductibles and co-pays. Within this strategy, employers are actively educating employees on their care options, including site of care and provider differences, while also encouraging healthy lifestyles, care management and disease prevention through cost-containment solutions highlighted earlier in this report.

Stop loss carriers cite the benefits of carve-out vendors for high-cost dialysis, transplants and infusions to mitigate risk and provide specialty, quality care (through third-party COE networks).

Reference-based pricing (RBP) is another tool that can help predict and control costs, whether for an entire group, select services or out-of-network claims.

Some carriers offer discounts and more favorable rates for groups implementing programs focused on controlling pharmacy spend, such as specialty carve-outs, 340B participation, formulary design, prior authorization protocols and international prescription drug sourcing. Patient Assistance Programs (PAPs) further enhance affordability, making high-cost medications more accessible.

Loyalty matters when it comes to securing better rates and terms. Groups that frequently switch stop loss carriers may be subject to stricter and more conservative underwriting, whereas long-term relationships allow for greater negotiation leverage and more favorable contract terms. Stop loss carriers value stability and can be more accommodating with groups that have demonstrated commitment across multiple years.

Impact of AI and Technology

In general, many carriers are cautiously optimistic about AI tools, viewing innovation as a valuable supplement to digest, interpret and summarize complex data sets more efficiently. While AI is not expected to replace human expertise, carriers view it as an additive tool to enhance efficiency in underwriting, sales and marketing, claims processing and audits.

AI can certainly reduce some manual processes and automate repetitive tasks, but human oversight remains essential to refining and validating outputs. Despite its potential, full AI integration remains complex and slow. Modifying existing workflows and adapting processes to accommodate AI models is multifaceted, especially with tight data privacy and security protocols required to handle PHI.

Carrier Concerns and Frustrations

Carriers note that when employers focus only on the stop loss premium, they may overlook broader financial risks or make short-sighted decisions without fully understanding the implications. Brokers are pivotal in educating employers and ensuring seamless integration across stop loss carriers, vendors and external service providers involved with each plan. Brokers can further support groups by proactively and thoroughly reviewing financial protections and Summary Plan Descriptions and requesting a review of sample contracts.

Given the overall growth in large-dollar claims materially impacting stop loss rates, pre-payment reviews and audits can reduce waste and group spending. Some proactive reviews indicate that up to 90% of high-cost claims would never reach the stop loss threshold if properly audited, as many expenses stem from artificially inflated charges or outlier provisions. Controlling claims on the front-end will naturally lower stop loss costs and rates.

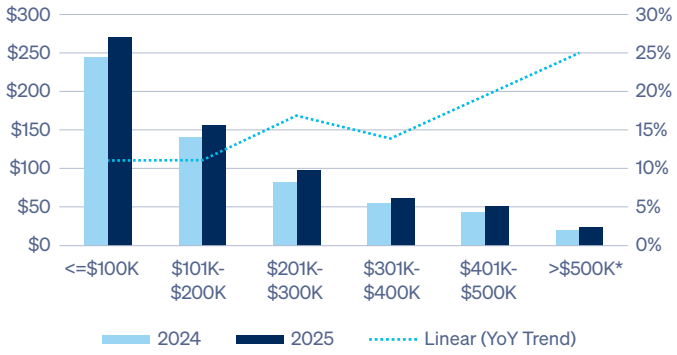
> **▶ In Action:**
> Data is critical to understanding existing healthcare claims and costs, but it can also illuminate forward-looking opportunities for overall plan improvement. One specialty vendor interviewed for this report conducted a deep dive into a client's spending and utilization. The assessment helped the client recognize more than $500K in billing errors. Payment integrity partners and initiatives — along with access to data and a push for industry-wide transparency — will continue to impact overall market efficiency and shine a light on gray zones and blind spots.

Benchmarking Data from Stealth's Book of Business

The following data encompasses groups of all sizes and structures across the entirety of the U.S. Brokers can use this information as a benchmark to compare similarly situated groups and guide employers toward stop loss solutions that most appropriately balance risk, cost and protection.

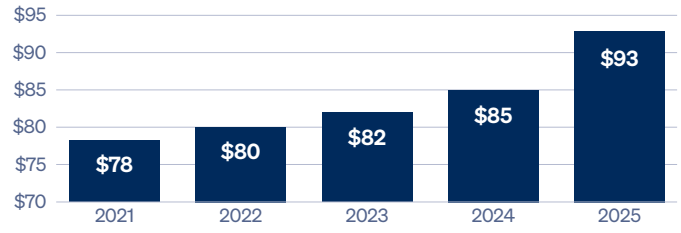
Stealth's independent nature and breadth of reputable partners — direct writers, BUCAs, niche MGUs and Amwins-owned proprietary markets — allow for a broad, unbiased view of industry trends and an understanding of corresponding impacts on employer groups.

Stop Loss Premium PEPM by Specific Deductible



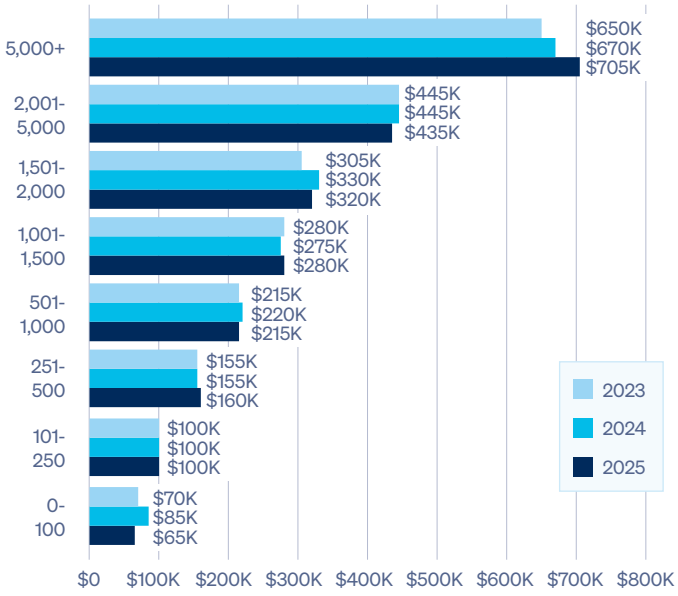
Groups with specific deductibles over $1.5M were excluded from this analysis, due to a low number of groups year over year.

Stop Loss Premium PEPM Over Time



These amounts are not normalized for market and do not reflect changes in book of business, deductible and/or lasers, etc. PEPM has been normalized for group size.

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



Key Takeaways

The average specific (spec) deductible by group size has remained relatively flat year-over-year, although the deductible is beginning to trend up for the largest groups (5,000+ employees). A decrease in the spec deductible at the smallest group size may be driven by the overall growth in smaller groups seeking out self-funding.

The average increase in premium PEPM has risen 10% from 2024 to 2025 compared to 2% to 3% in years prior. In addition to groups not increasing spec deductibles, Stealth's book of business reflects the industry-wide trend of smaller groups — also with lower spec deductibles — moving toward self-funding. Lower spec deductibles and the influx of smaller self-funded groups are likely contributing to the PEPM increase in Stealth's book and across the stop loss market.

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

	2024	2025
% Elected Aggregating Specific Deductible	27.9%	27.5%
% Premium Decrease	17.2%	14.2%

Key Takeaway

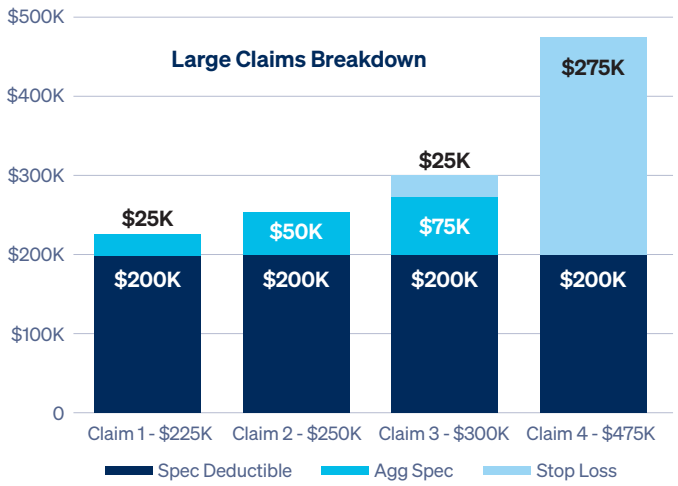
Overall, similar to last year, a consistent number of groups elected an agg spec deductible. The prevalence of aggregating specific deductibles is consistent across all levels, indicating it is a risk and cost mitigation solution employed by groups regardless of size or specific deductible. Given the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

▶ In Action: Leveraging an Aggregating Specific Deductible to Reduce Premium

Specific Threshold for Group: $200K
Aggregating Specific Deductible: $150K

In this example, the policyholder is electing an agg spec deductible to pay a reduced premium in exchange for taking on additional risk. It can be satisfied by one claimant or multiple claimants and is often a dollar-for-dollar offset.

The agg spec deductible is an additional layer before the stop loss carrier starts paying for claims. Unlike a laser, multiple specific deductible breaches can accumulate toward the agg spec deductible.



Stop Loss Coverage by Industry

Rank	Industry	% of Groups	Group Size Range*	Median Spec Deductible	Median Premium PEPM
1	Manufacturing	18%	80-1,200	$135K	$180
2	Health Care and Social Assistance	13%	100-1,800	$150K	$150
3	Professional, Scientific and Technical Services	8%	90-1,200	$125K	$190
4	Wholesale Trade	7%	80-1,700	$130K	$170
5	Public Administration	7%	150-1,500	$150K	$160
6	Educational Services	6%	90-3,100	$160K	$160
7	Finance and Insurance	6%	110-4,000	$195K	$140
8	Construction	6%	100-1,400	$125K	$170
9	Other Services (except Public Administration)	6%	70-1,800	$175K	$160
10	Retail Trade	5%	80-1,100	$125K	$170

Key Takeaway

Of the industries where Stealth places stop loss, manufacturing holds the top spot, with almost 20% of all groups. Finance and insurance tend to have the largest groups — selecting higher deductibles and slightly lower premiums. Across the board, Stealth places business in groups of all sizes, from just under 100 lives to several thousand.

*80% of groups are within this employee size range.

Groups (by Size) Purchasing Aggregate Coverage

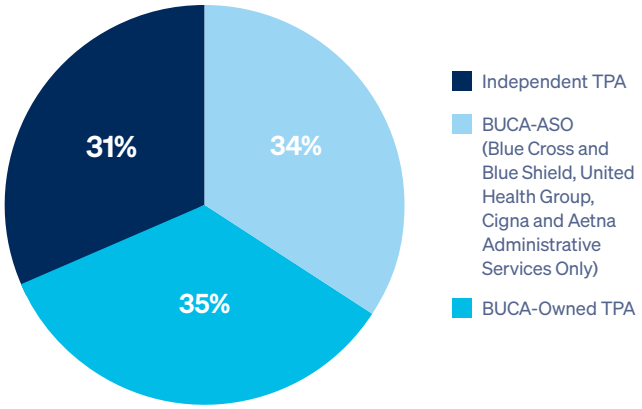
	% of Cases with Aggregate Coverage		
Group (EE) Size	**2023**	**2024**	**2025**
0-100	87%	85%	89%
100-250	86%	87%	86%
250-500	75%	78%	76%
500-1,000	65%	66%	65%
1,000-1,500	44%	44%	46%
1,500-2,000	52%	46%	36%
2,000-5,000	12%	18%	23%
5,000+	12%	7%	7%

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, the majority of groups with less than 1,000 employees do elect aggregate coverage.

Note: While it may look odd to see any groups of more than 5,000 employees with aggregate coverage, some entities (like school districts or state organizations) are legally required to purchase aggregate coverage. Some states also require entities to elect aggregate coverage.

Self-Funded Administration



Key Takeaway

Groups choosing self-funded administration tend to be evenly distributed between three categories: BUCA-ASO, BUCA-owned TPA and Independent TPAs. Groups selecting BUCA ASO tend to be larger — 60%+ are covering 1,500 or more employees. Groups selecting an Independent TPA tend to be much smaller — nearly 60% cover less than 100 employees. On average, a group with the BUCA network has just over 1,000 subscribers, while groups with an Independent TPA are over 55% smaller.

▶ In Action: The Complex Interplay of Rx Rebates, Aggregate Hits and Stop Loss Recouping

In the event of an aggregate hit, stop loss carriers will require prescription drug rebate data for that policy year. The rebate amount is then deducted from the total aggregate reimbursement regardless of whether the Plan sponsor is the direct recipient of the rebates. Even if the administrator is retaining the rebates to offset administrative costs, the rebates will still be included in the final aggregate claim calculation.

Due to the infrequency of agg hits, the interconnectivity between rebates, agg hits and stop loss is not widely understood in the self-funded space. However, the financial impacts of pharmacy rebates are becoming more significant. Brokers can proactively align their clients' expectations with possible circumstances by educating plan sponsors on this complex and emerging dynamic.

Recommended Best Practices

65+	3M	2,900	37,505
Carrier Markets	Lives Covered	Employer Groups	Spec Claims Reimbursed*

Designing a comprehensive and cost-effective employer health plan requires a flexible approach, and brokers must invest time into understanding the litany of options. While stop loss is just one component of a self-funded plan, gray areas in eligibility and ambiguity in plan design can lead to unintended stop loss reimbursement delays or denials. Here are just a few of Stealth's recommended best practices.

Prevent Stop Loss Claims Denials

Eligibility issues, insufficient documentation in employee handbooks and plan documents, and inconsistent administration of leave policies are the most common reasons for a stop loss claim denial. Employers without a dedicated benefits/leave manager or robust Human Resources team struggle most with developing and managing proper documentation.

Clear language must detail the dates coverage begins and ends and include specifications for leaves of absence of any type — COBRA, maternity and paternity leave, and FMLA, to name just a few. Paid time off (PTO) and non-paid leave policies must also be clearly referenced in an employer's leave policy, especially if they may run concurrently with FMLA. Mandated leave policies vary from state to state, so brokers must stay current on any location-specific changes.

In Stealth's book of business, less than 1% of stop loss claims are fully denied.

* 2024 calendar year.

Carriers strictly reimburse based on plan documents, and the use of "AND" versus "OR" (or vice versa) can have big implications on coverage and reimbursement. Inconsistent or incomplete documentation can lead to coverage gaps, but consistent and clear documentation enables a faster claims process with less disruption.

Employers and brokers should conduct annual or bi-annual reviews of Plan Documents to ensure clarity and alignment with carrier policies. Integrating cell and gene therapy language into Plan Documents is strongly recommended.

Request Plan Mirroring

Stealth's experts utilize plan mirroring to help resolve conflicts between covered expenses outlined in the health plan document and the limitations/exclusions specified in the stop loss contract.

While plan mirroring may help resolve a discrepancy between interpretations and definitions, it does not negate exclusions listed on the stop loss policy or reimburse for "administrative" or "document review" fees. Ideally, the stop loss carrier should defer to the plan document and honor eligible claims under its terms.

Tasks performed as part of standard medical administration are often classified as "administrative fees." For example, payment to a vendor tasked with reviewing a claim for accuracy without negotiating is considered an administrative function, not classified as a reimbursable cost. However, if a vendor negotiates an out-of-network claim and secures measurable savings, carriers may reimburse a percentage of the savings achieved.

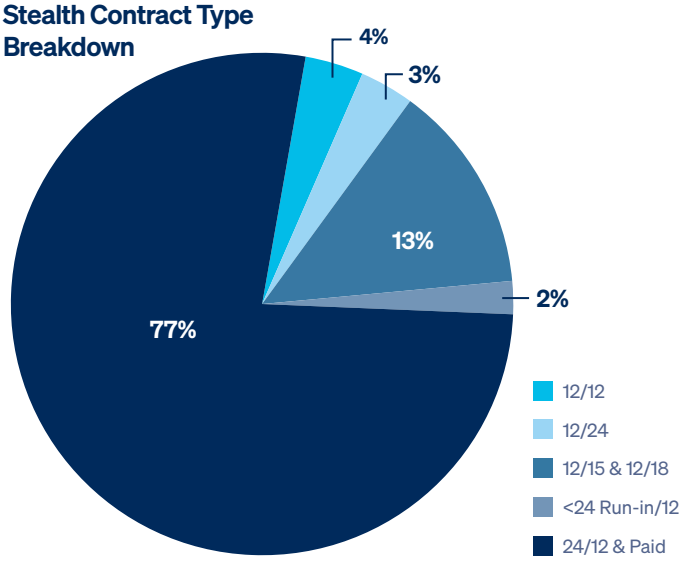
Ensure Adequate Run-In and Run-Out Provisions

Complex claims take longer to adjudicate, particularly those from large network providers. Underlying plan documents often stipulate a 12-month submission window, and network agreements allow providers up to a year 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 trend of industry-wide timelines. While some clients may opt for shorter runways of three or six months, the potential pricing implications are a minimal tradeoff for adequate coverage duration.

Stealth Contract Type Breakdown



Compared to our 2023 and 2024 State of the Market reports, the distribution by contract types remained consistent, with the majority of contracts sold on a paid basis.

Acknowledge and Adapt to Regional Nuances

Understanding the types of claims and health conditions most likely to impact populations in a specific state, region and market is extremely helpful. For example, babies conceived through in vitro fertilization (IVF) experience a slightly elevated risk of preterm birth, and 11 states require both IVF and fertility preservation coverage. Individuals in the Southern U.S. are impacted with elevated incidence rates of cancer and cardiovascular conditions, while ESRD disproportionately affects African Americans, Hispanics and Native Americans.

By recognizing regional and demographic patterns and interpreting employee health trends, brokers can identify cost-saving opportunities and more effectively tailor employer-sponsored healthcare plans for covered individuals and their families.

Stay Informed and Communicate Often

The value an informed broker brings to a client — and to the ever-shifting market as a whole — stretches far beyond a renewal rate or a discount. Understanding stop loss trends and available niche solutions for the growing segment of self-insured groups is critical to demonstrating value and staying compliant with ERISA's fiduciary requirements.

Building thoughtfully tailored, client-focused plans with niche partners and forward-thinking stop loss experts does take time, and coordinating multiple partners and programs can be complex. Communicating frequently with stop loss carriers will help ensure potential discounts are applied and claim negotiation fees are part of the reimbursement.

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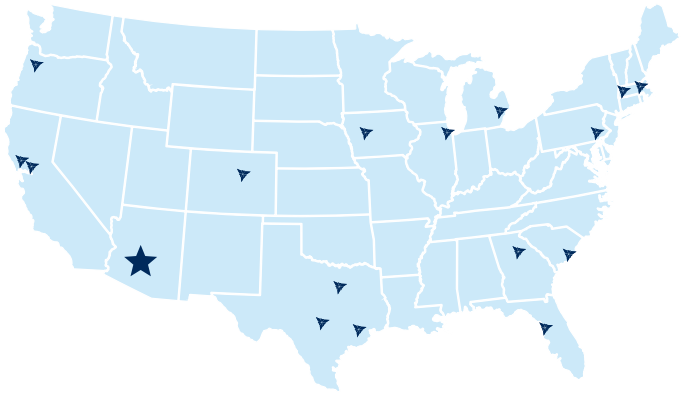
While the core health conditions contributing to stop loss claims — such as kidney disease and dialysis, hospitalizations, cancers, transplants and premature births — will continue to be consistent drivers of high-cost claims, new and emerging variables in this report (such as high-cost specialty drugs, infusions and novel therapies) will pose evolving challenges for actuaries, carriers, brokers and groups.

Critical nuances such as geography, culture and expectations of each group also play into developing creative and effective coverage plans. There is much to know, and brokers are obligated to ensure that their clients have the guardrails in place now to protect against the unknown risks ahead.

Stealth's independent, third-party experts bring unmatched knowledge and expertise within the dynamic stop loss marketplace. We offer a synergistic suite of group benefits programs and products through our ancillary division and continue to elevate those offerings as client needs evolve.

As a company, Stealth is continuously improving its internal data and reporting capabilities to better support its broker partners. We are committed to strengthening productive, long-term partnerships with brokers and consultants who are similarly determined to deliver strategic, competitive and valuable solutions to clients at every turn.



#1 Largest Stop Loss Managing General Agency	**$2.3B+** Premium Placements	**300** Employees Nationwide	**30** National Producers
3M Lives Covered	**2,900** Groups	**65+** Carriers/Markets	**17** Office Locations

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