Your health plan is a *profit lever*

For employers tired of accepting the annual increase — here's what's actually happening inside your plan, and what you can do about it.

PER EMPLOYEE, PER YEAR

$17K+

Projected annual employer health cost per employee in 2026

LARGEST CONTROLLABLE COST

2nd

Behind payroll — and rarely negotiated with the same rigor

WHAT IT USED TO COST

Doubled

Average family coverage in a decade — from $782 to $1,232/month

By Bruno Nascimento

Wellnest insurance

Table of Contents

Your health plan is a *profit lever.*

Most small businesses treat healthcare costs as weather — uncontrollable, unpredictable, inevitable. They're not. I've spent the last 16 years inside group health renewals — fully insured, level-funded, and self-funded. Here's what I've learned about where the money goes, and what can be done about it.

01 The Problem:
The Renewal Trap — And How It's Designed To Work

Every year, 60–90 days before your plan anniversary, a packet arrives. Your broker schedules a call. The number on the spreadsheet is higher than last year. There's a brief conversation about options. Maybe you switch carriers, maybe you raise the deductible, maybe you quietly increase the employee contribution. Then everyone moves on.

This happens at companies that negotiate everything. Lease rates, vendor contracts, equipment financing. Yet the second or third largest expense on the books gets a 45-minute call once a year and a signature.

Three core problems define every renewal like this — the broker who has no real leverage, the carrier who holds the data, and the employer who has no idea whether the rate increase is justified. All three are fixable. None require switching carriers or cutting benefits.

> ***"When your broker says costs only went up 8% this year, they're really saying: your take-home profit just dropped again."***

THE NUMBERS BEHIND THE PATTERN

> Health insurance costs for small employers are now growing at the fastest rate in over two decades. The median proposed increase across 318 small group insurers nationwide in 2026 is 11% — and 1 in 10 are proposing 20% or more.

The compounding effect is what most employers never visualize. A company absorbing real-world renewal volatility doesn't just pay more each year. Over a few years, it overspends significantly compared to what an actively managed plan would have cost. That's not healthcare inflation. That's the cost of an unmanaged plan.

WHY THE TRAP IS SO WELL DESIGNED

The process is structured to make alternatives feel risky, complicated, and not worth the disruption.

1 Mechanism — Data is withheld by design

On a fully-insured plan, the carrier owns your claims data. You cannot see which conditions are driving costs, which pharmacy claims are inflated, or whether your group's actual utilization justifies the rate increase. You are negotiating blind — and the carrier knows it.

2 Mechanism — The benchmark is rigged

"The industry average is 14% and you're only at 11%" is not good news — it's misdirection. The relevant benchmark is not what other groups are paying. It's what your group should be paying based on its own claims, workforce health, and plan structure.

3 Mechanism — The only options presented cost more or hurt employees

Raise the deductible. Increase the employee contribution. Switch to a narrower network. Every one of these either shifts cost to your workforce or reduces benefit quality. None address what's actually driving the increase.

4 Mechanism — Switching feels riskier than staying

Changing carriers means disrupting employee care, reissuing ID cards, recredentialing providers. The friction is real — and carriers know that inertia is their most powerful retention tool. Most employers stay not because they're satisfied, but because leaving feels like more work than it's worth.

WHAT THIS GUIDE COVERS

The sections that follow walk through where your plan dollars actually go, the specific mechanisms that drain them, and the structural and operational steps that put control back in the employer's hands. The tools exist. Most employers have simply never been shown them.

02 The Solution: How To Take Back Control — Starting With The Right Structure

Three types of employers tend to find their way to this guide. The first is still fully insured — paying a fixed premium with no data, no leverage, and no idea why costs keep climbing. The second moved to level-funded but hasn't seen the results the structure promises — usually because the advisor managing it isn't doing much managing. The third is on the right path but knows there's more performance to unlock. Each one has a next step. None of them require starting from scratch.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

WHERE ARE YOU STARTING FROM?

STARTING POINT A

Still on a fully-insured plan

The carrier sets the rate. You accept it — with no visibility into what's driving costs and no real leverage to change it.

The structure needs to change

STARTING POINT B

On level-funded but underserved

You have the right structure but your broker isn't reading the data, isn't negotiating terms, and only shows up at renewal. The plan's potential is going unrealized.

The management needs to change

STARTING POINT C

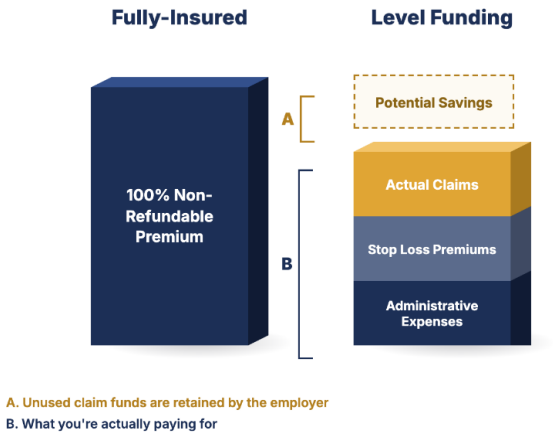
Level-funded and actively managed

You're on the right track. The question is whether every lever is being pulled — pharmacy, pricing, care access, and communication — and whether the data is driving real decisions.

The depth needs to increase

> ***"Fully-insured plans are engineered for carrier profitability, not employer savings. Level funding is what cost-conscious companies move to once they understand how the math actually works."***

Here's what the structural difference looks like, dollar for dollar.



Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

FOR THOSE STILL ON FULLY-INSURED — WHY THE STRUCTURE MATTERS

Dimension	Fully Insured **Carrier holds all the risk — and all the control.**	Level Funded ↑ **You own the data, the upside, and the vendor relationships.**
Monthly cost	Fixed premium — identical whether your group has zero claims or high claims	Fixed monthly amount — surplus returned if claims run below projections
Claims data	Carrier property. Summaries only — never individual claim detail	Full access. Every claim, every pharmacy transaction, every cost driver
Vendor control	Carrier selects your TPA, PBM, and network. You inherit their contracts	You select or negotiate vendors — including a fiduciary PBM with full rebate pass-through
Good year benefit	Carrier keeps the surplus. Your healthy group funds their profit margin	You may receive a surplus refund if claims run below projections. In well-managed groups, that can range 10–20% of annual premium.
Catastrophic risk	Carrier absorbs all risk — predictable but expensive by design	Stop-loss insurance caps your exposure on both an individual and group-wide basis
Renewal leverage	Almost none. You are a price taker. The carrier sets the rate.	Significant. Your own claims data lets you negotiate from fact, not carrier projections

Source: KFF Employer Health Benefits Survey 2025 — 37% of covered employees at companies with 10–199 workers are now on level-funded plans, up from just 7% in 2019.

FOR THOSE ALREADY ON LEVEL-FUNDED — WHAT ACTIVE MANAGEMENT LOOKS LIKE

A level-funded plan where the broker isn't reading the claims data, isn't negotiating carrier and vendor terms, and isn't making proactive recommendations between renewals is not a managed plan. Here are the four things that should be happening between renewals, not just at them.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

1 Quarterly claims review

Identifies top cost drivers, pharmacy concentration risks, and utilization patterns before they compound into a renewal increase. If your broker has never shown you a claims report outside of renewal — the data exists but no one is using it.

2 Fiduciary PBM

Contractually required to pass through 100% of manufacturer rebates at transparent flat fees — eliminating spread pricing and retained rebates. For a 50-person plan, this alone could recover tens of thousands annually without changing a single benefit.

3 Price transparency tools

The same MRI costs $380 at one facility and $2,800 at another five miles away. A cost comparison tool redirects spend without restricting access or cutting a single benefit. Available to any level-funded employer. Most never use it.

4 Front-door care strategy

Direct Primary Care ($50–$100/employee/month) gives employees zero-copay, same-day physician access — eliminating the ER default for non-emergency conditions. Groups with DPC in place typically see 3–5x the program cost in downstream claim reductions.

THE LEVEL-FUNDED TRAP

A level-funded plan with a passive broker is just a fully-insured plan with more moving parts and the same outcome.

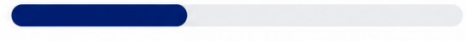
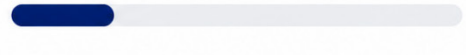
If your broker can't tell you what your top five cost drivers were last year, what your pharmacy rebate pass-through rate is, or what your ER utilization looked like relative to benchmark — the data exists but no one is using it. The plan structure is right. The management is not. The difference is a plan that compounds savings year over year versus one that still produces a double-digit renewal.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

03 The Money:
Where It Goes — And Where It's Being Wasted

Most employers have never seen a true breakdown of their health plan spend. They see a premium total, a renewal percentage, and a benefits summary. What they don't see is how that money actually moves — and which parts of it are working against them.

HOW A TYPICAL PLAN DOLLAR BREAKS DOWN

CATEGORY	RELATIVE SIZE	SHARE
Hospital care Inpatient stays, surgeries, ER		28–31%
Prescription drugs Including specialty & GLP-1s		24–27%
Physician & outpatient Specialist visits, imaging, labs		15–18%
Mental health & behavioral Up 53% since 2020		8–12%
Admin, network fees & carrier margin Overhead, profit, undisclosed compensation		18–25%

Sources: KFF Employer Health Benefits Survey 2024 · Business Group on Health 2025 · CMS National Health Expenditure Data 2024 · Milliman Medical Index 2024

> ***"Roughly 90% of every health plan dollar is tied to chronic and ongoing conditions. The employers who control that number are the ones who stop treating their plan as a product and start treating it as a system."***

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

THE FIVE WASTE CATEGORIES THAT SHOW UP IN EVERY PLAN REVIEW

Waste concentrates in the same five places regardless of carrier or industry. Here's what we address first.

1 PHARMACY — 24–27% of total plan spend

Traditional PBMs keep the difference between what they charge your plan and what they pay the pharmacy — and pocket manufacturer rebates that should reduce your costs. Most small employers have never seen this itemized. Potentially recoverable: 15–30% of pharmacy spend, depending on your current PBM contract terms.

The fix: replace your PBM with a fiduciary pass-through model — covered in Section 4, Step 1.

2 HOSPITAL BILLING — 10–15x price variation, same procedure

A network discount sounds like protection — but when the starting price is inflated 3–5x, even a 40% discount is a significant overpayment. Without price transparency tools, small employers absorb this quietly at every renewal. The same MRI can run $400–$4,000 within the same zip code.

The fix: price transparency tools and direct facility contracts — covered in Section 4, Step 2.

3 SPECIALTY DRUGS — 50%+ of pharmacy spend from specialty alone

The vast majority of employers now cover GLP-1s for diabetes treatment, but two or three employees on unmanaged GLP-1s or biologics can meaningfully increase pharmacy costs — often in the range of 25–35% in plans we've reviewed. Most small employers have no prior authorization program in place.

The fix: plan-level prior authorization criteria and biosimilar substitution programs — covered in Section 4, Step 2.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

4 CHRONIC DISEASE — 90% of spend tied to chronic conditions

The biggest claims don't arrive without warning — they arrive after years of inadequate primary care. Low-value musculoskeletal care alone is one of the largest sources of avoidable waste across employer plans nationally, often tens of billions industry-wide each year.

The fix: Direct Primary Care and condition management programs — covered in Section 4, Step 3.

5 MISROUTED CARE — $2,000+ extra cost per avoidable ER visit

The average ER visit runs $1,500–$3,000 for conditions urgent care handles for $150–$200. A significant share of covered employees have no primary care provider, which leaves the ER as the default front door for care. In a 50-person group, meaningfully reducing avoidable ER visits has the potential to recover $40,000–$80,000 annually, depending on current utilization.

The fix: virtual care access and a year-round employee communication strategy — covered in Sections 4 and 5.

THE OPPORTUNITY

Every one of these categories has a fix. None require cutting benefits or switching carriers. **This isn't theoretical.** I've done this with groups nationwide — hundreds of thousands in annual renewal savings, without disrupting employee coverage.

See where your plan is leaking. A free plan review shows you which of these categories apply to your group — and what's recoverable. No obligation.

REQUEST YOUR FREE PLAN REVIEW

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

04 The Timeline:
The Three-Step Path — To A Plan That Pays For Itself

Most employers spend years absorbing increases that a three-step process could have stopped. Each step is funded by the results of the one before it. By year three, many employers see renewals begin to flatten out while the market keeps climbing.

THE STEPS IN DETAIL

STEP 1 · FIX THE STRUCTURE AND THE VENDORS ·
YEAR 1 · *at your renewal or any point mid-year · 30–60 days*

Move to level-funded and replace the PBM with a fiduciary model that passes 100% of rebates back to your plan. Your employees don't notice a change. What changes is who's profiting from the plan.

What happens

- Level-funded structure
- Fiduciary PBM
- Stop-loss right-sized
- All vendor contracts audited

PBM essentials

- 100% rebate pass-through
- Disclosed spread
- Audit rights
- Flat fee

STEP 2 · USE YOUR DATA TO CUT THE BIGGEST COSTS ·
YEAR 2 · *built on what Step 1 reveals*

After 12 months of claims data, your advisor identifies exactly where money is leaking and executes targeted fixes. The two biggest targets: pharmacy concentration and facility cost variation.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

Specialty drugs

Plan-level prior authorization criteria for GLP-1s and biologics · biosimilar substitution programs · manufacturer assistance program enrollment support

Price transparency

Cost comparison tools so employees see real facility prices before scheduling — same procedure, 10–15x cost difference

STEP 3 · GIVE EMPLOYEES A FRONT DOOR — AND STOP THE ER DEFAULT · YEAR 3 · *typically funded by Steps 1 and 2*

Add Direct Primary Care or virtual care — giving employees zero-copay, same-day access to a doctor. When employees have a real alternative, ER defaults drop. This step is typically funded by what Steps 1 and 2 already saved.

Direct Primary Care

- $50–$100/employee/month
- Zero-copay same-day access
- Often 3–5x the program cost in downstream claim reductions

ER diversion

A 30% reduction in avoidable ER visits has the potential to recover $40K–$80K annually on a 50-person plan.

> ***"You don't need a bigger budget to fix your health plan. You need a strategic advisor with the budget you're already spending."***

WHAT YOU MAY BE THINKING RIGHT NOW

"We just renewed." Great — that means you have 10–11 months before the next renewal to build real leverage instead of reacting to a spreadsheet under deadline pressure. The best time to start this process is right after a renewal, not right before one.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

"This sounds complicated." It isn't. These are three conversations spread across three years — not three projects — each one funded by the result of the last. Your time investment in year one is a single decision and two meetings.

"We're happy with our current broker." If your broker is doing everything broken down in this guide — quarterly claims reviews, PBM audits, price transparency, proactive vendor negotiation — keep them. If not, a second set of eyes costs you nothing to find out what you're missing.

05 The Multiplier: Communication — The Lever That Makes Everything Else Work

A DPC benefit no one knows about doesn't divert a single ER visit. A cost comparison tool employees never open doesn't redirect a dollar of hospital spend. The best-designed plan in the world only performs as well as the employees who use it.

> ***"You can build a perfect plan and still lose money on it. The best health plan in the world performs exactly as well as the employees who use it."***

THE NUMBERS BEHIND THE GAP

It's a reflection of employees who were handed a benefits card at onboarding, pointed to a summary plan document, and never heard from HR about their benefits again. In fast-growing companies especially, benefits communication tends to get deprioritized — and the claims data always shows it.

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

THE THREE COMMUNICATION FAILURES THAT SHOW UP IN CLAIMS DATA

1 FAILURE: MOST of ER visits are non-emergent

Employees default to the ER — when there's no clear guidance on alternatives, the path of least resistance wins every time. A significant share of covered employees have no primary care provider — which leaves the ER as the default front door for care.

2 FAILURE: 80–85% less expensive — generic vs. brand-name

Prescriptions filled at the wrong pharmacy or in the wrong tier Most employees don't know that asking for the generic equivalent can cost the plan 80–85% less. Different pharmacies charge different prices for the same drug — always compare before filling.

3 FAILURE: $0 cost of preventive care

Preventive benefits go unused — and conditions go undetected. Preventive visits are fully covered at zero cost — yet participation stays low. Diabetes caught early is a manageable, budgetable plan cost. Left undiagnosed, it tends to surface later as a hospitalization — the kind of claim that reshapes a renewal.

> ***A free benefit costs nothing to use — but left unused, it can cost employees and employers far more down the road.***

Disclaimer: Figures are industry benchmarks, not guaranteed outcomes. Individual results vary by group.

WHAT GOOD COMMUNICATION LOOKS LIKE FOR A GROWING BUSINESS

It's not an annual open enrollment meeting. It's not a 60-page benefits guide no one reads. Effective benefits communication is short, specific, and timed to the moment when an employee is about to make a care decision.

When	Message	Primary impact
Sept–Oct	Open enrollment walkthrough — 20-minute session explaining how the deductible works, where to go for what kind of care, how to access virtual care, and how to use the cost comparison tool.	Correct care routing from day one
Nov	Flu season ER reminder — three sentences reminding employees that flu, minor infections, and non-emergencies are handled faster and cheaper through virtual care or urgent care.	ER diversion during peak season
Jan	Deductible reset + preventive reminder — annual physicals, screenings, and wellness visits are covered at zero cost. Schedule in January before the year fills up.	Early detection, lower downstream claims
Mar–Apr	Prescription check-in — how to request generics, use mail-order for maintenance drugs, and check drug costs before filling. One message, measurable pharmacy savings.	Generic utilization, pharmacy cost reduction

Want the full calendar?

A ready-to-use, 12-month communication calendar — pre-written, employer-branded, and free.

⬇ GET THE FREE CALENDAR

www.wellnestinsurance.com

THE BOTTOM LINE ON COMMUNICATION

A well-structured plan that employees understand outperforms a perfect plan they don't. Communication is the multiplier that ties every strategy in this guide together — and it doesn't happen by accident. It takes a deliberate, year-round strategy, built and managed by an advisor who treats your health plan like the financial asset it is.

Conclusion:
The Renewal Doesn't Have To Win Anymore

Health insurance is the only major business expense where accepting an annual increase is considered normal. No negotiation. No benchmark. No explanation of what changed. Just a new number, a shrug, and the same conversation you had twelve months ago.

Everything in this guide is already being used by businesses across the country. What's missing for most employers is simply an advisor who knows how to put the pieces together — and a willingness to have a different conversation at the next renewal.

> ***"Most employers don't have a healthcare cost problem. They have an advisor problem — and every year they accept the renewal is a year they funded someone else's profit instead of their own."***

WHAT THIS GUIDE COVERED

1. The renewal process is engineered to produce one outcome — your acceptance. Understanding why it works that way is the first step to changing it.
2. Most of your health plan dollars flow through vendors whose incentives run counter to yours. That's not bad luck. It's by design — and it's fixable.
3. Level funding doesn't just change your plan structure. It changes your position — from price taker to plan manager, with data, vendor control, and upside when your group has a good year.
4. The three-step roadmap pays for itself. Year one funds year two. Year two funds year three. It's a reallocation of money already being spent — not an added cost.
5. Communication is the variable that determines whether a well-built plan actually performs. It costs almost nothing and multiplies everything else in this guide.

THE ONLY QUESTION THAT MATTERS NOW

At your next renewal, your current broker will bring a spreadsheet. It will show an increase. There will be two or three options — all of which involve either paying more or giving employees less. You will be told this is the market.

If your broker isn't doing what this guide describes, the plan's potential is being left on the table. The question is whether you want to have a different conversation.

About The Author

Bruno Nascimento

Group Benefits Strategist

Licensed independent insurance agent since 2010 (NPN 15972653)

Bruno works with business owners nationwide who are tired of accepting health insurance renewals as inevitable. He specializes in building cost-effective group health strategies that reduce what employers pay, improve the care employees receive, and turn the annual renewal from a dreaded expense into a managed business decision.

> ***Your health plan is either working for you — or it's working for someone else.***

YOUR NEXT STEP

Ready to see what your *current broker hasn't shown you?*

Get a Free Plan Review.

We'll show you exactly where the money is leaking, what's recoverable, and what a better strategy could look like. No obligation. Just clarity. Most employers walk away with a very different view of their renewal.

SCHEDULE YOUR FREE PLAN REVIEW

wellnestinsurance.com linkedin.com/in/brunoinsurance

bruno@wellnestinsurance.com 888-261-3584

The figures, ranges, and examples in this guide are drawn from industry data and general plan-performance trends. Actual results vary by group size, claims history, industry, and current plan structure, and are not guaranteed. This guide is for general informational purposes and does not constitute a quote, an offer of coverage, or a recommendation specific to your plan. Speak with a licensed advisor to evaluate your group's specific situation.