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Financing Healthcare

How self-funded health plans work, and what they ask of an employe

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Previously from California (Orange County & Sacramento) and Seattle

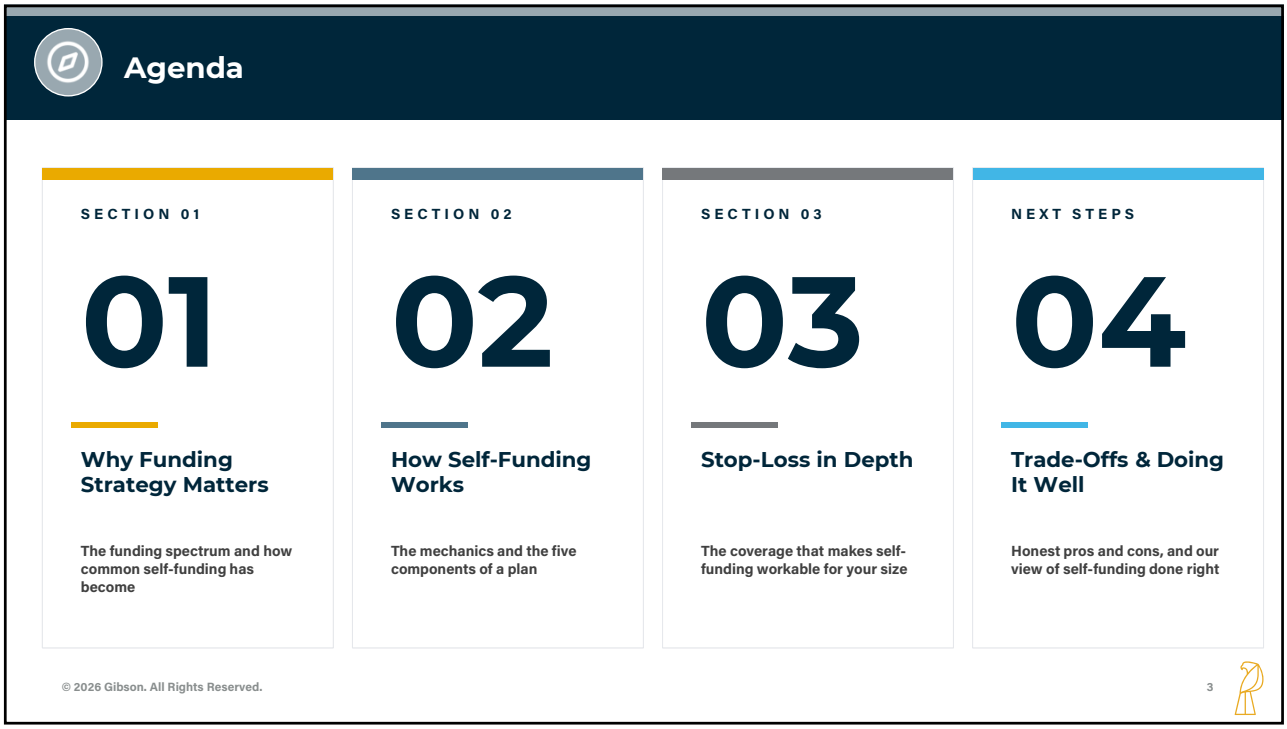
- 18 years in the HCM/Payroll Technology space with ADP, Paychex, and Paycor
- 9 years living and working in Arizona
- Passionate about employee benefits — because benefits are personal, and benefits save lives

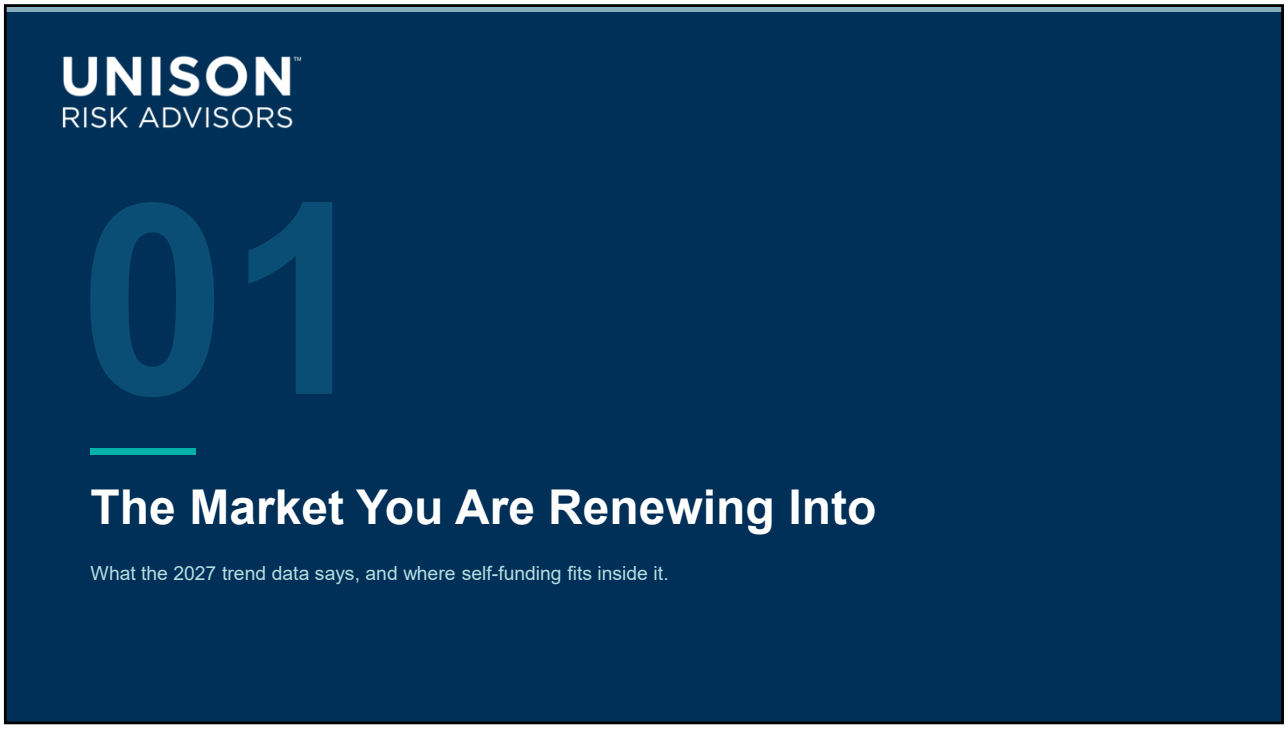




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2027 Trend Is Approaching a 15-Year High

Segal surveys the carriers, PBMs, and third-party administrators every year and asks what they are building into next year's rates. This is what they said for 2027.

9.9%

Projected medical trend

The median increase carriers expect on medical claims in 2027, and the highest projection Segal has published in roughly 15 years.

11.5%

Projected prescription drug trend

Pharmacy climbs faster than medical again, pushed by specialty drugs and by weight-loss medications reaching more people.

WHAT IS PUSHING IT, IN PLAIN TERMS

Hospitals and doctor groups keep merging
Fewer, bigger systems in each market means more leverage to raise prices.

Medicare and Medicaid pay less every year
Hospitals make up the difference by charging employer plans more.

Expensive drugs are replacing cheaper ones
Specialty and weight-loss medications are reaching far more people than anyone modeled.

The workforce is older and sicker
More chronic conditions in the population means more care, year after year.

The same visit gets billed at a higher level
AI-assisted coding documents more severity on identical episodes of care.

None of it reverses on its own
And none of it is something a renewal negotiation can reach.

Source: 2027 Segal Health Plan Cost Trend Survey, Segal's 30th annual survey of trend projections.

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Five Ways to Fund a Group Health Plan

Ordered from least to most employer risk. Each trades risk for control and data access differently. Today we focus on the two on the right.

LOWEST RISK
ICHRA

Defined-contribution funding toward individual-market coverage.

- Risk sits with carriers
- Limited claims visibility
- Very high design flexibility

SIMPLEST ADMIN
Fully-Insured

The carrier holds all claims risk for a fixed premium.

- Premium is the only lever
- Minimal claims transparency
- Surplus stays with the carrier

FIRST STEP OUT
Level-Funded

Fixed monthly cost with a year-end reconciliation.

- Capped employer risk
- Moderate claims visibility
- Partial refund in favorable years

TODAY'S FOCUS
Self-Funded + Captive

Pooled risk sharing across a membership of employers.

- Shared stop-loss layer
- Full claims transparency
- Pool absorbs volatility

TODAY'S FOCUS
Self-Funded + Stop-Loss

The plan pays its own claims; stop-loss caps the tail.

- Bounded employer risk
- Full claims transparency
- Surplus retained by the employer

Lower employer risk → **Greater control, data access, and upside**

Inside a fully-insured plan the only levers are the rate, the deductible, and how much premium employees pay. All three take something away, and none of them touch what the plan is actually paying for. That is why employers keep moving right on this menu.

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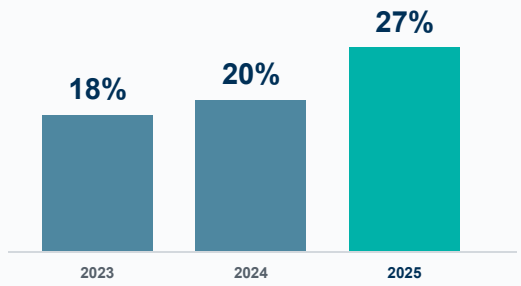
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Small-Employer Self-Funding Is Accelerating

Share of covered workers at small firms enrolled in a self-funded plan, per the KFF Employer Health Benefits Survey.

FIRMS WITH UNDER 200 WORKERS



Up 9 points in two years, with the steepest move in the most recent year.

80%

of covered workers at firms with 200 or more

are in a self-funded plan. Self-funding has been the settled default above 200 lives for years, and the mid-market is following it down.

16M

net shift into self-funded group plans, 2013 to 2023

Self-funded group enrollment rose by roughly 16 million over the decade while fully insured group enrollment fell by about 14 million.

THE TAKEAWAY

The direction of travel is settled.

Employers are leaving fully-insured plans, and the smaller ones are leaving fastest. The question is no longer whether to take on the risk. It is whether you can manage it well once you do.

Sources: KFF Employer Health Benefits Survey, 2023, 2024, and 2025; Peterson-KFF Health System Tracker. KFF defined small firms as 3 to 199 workers in 2023 and 2024 and as 10 to 199 workers in 2025, so part of the most recent increase reflects that change in survey universe.

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Fully-Insured and Self-Funded, Side by Side

	FULLY-INSURED	SELF-FUNDED
Who holds the claims risk	The carrier	**The employer, capped by stop-loss**
What you pay each month	Fixed premium, set in advance	**Actual claims plus fixed costs**
Visibility into claims	Little to none	**Full: conditions, drivers, spend**
A favorable claims year	The carrier keeps the margin	**Surplus remains with the employer**
Levers you control	Premium only	**Design, network, pharmacy, vendors**
Premium tax and risk margin	Built into the premium	**Comes out of the cost**

In a self-funded plan, the employer is the plan. The member experience is unchanged, and every lever that matters sits on the employer's side.

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How Self-Funding Works

The core mechanic and the components that run the plan

What a Self-Funded Plan Actually Is

THE CORE CONCEPT

The employer pays for actual claims as they happen, rather than a fixed premium to a carrier.

Each month the plan funds three things:

Paid claims	Actual medical and pharmacy claims. Variable, and by far the largest line.
Fixed costs	Administration, pharmacy contracting, stop-loss premium, network access.
Reserves	Funding for claims incurred but not yet reported (IBNR).

WHAT STAYS THE SAME

To your employees, the plan looks and works like any other.

- One ID card, and national networks of providers, facilities, and pharmacies.
- Deductibles, copays, and coinsurance can be mapped to what members have today.
- Open enrollment, eligibility, and member support run the same way.
- What changes sits behind the scenes: the employer holds the claims risk, and gains full visibility into where every dollar goes.

Stop-loss insurance caps how much the claims risk can ever cost in a single year, which is what makes this workable for small and mid-market employers.

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The Six Components of a Self-Funded Plan

A self-funded plan is assembled from parts that a fully insured carrier normally bundles together. Each can be chosen on its own merits.

TPA

The third-party administrator runs the plan day to day: adjudicates claims, pays providers, issues ID cards and EOBs, and gives the employer claims reporting.

Network

The provider network the plan rents for access and discounts. National or regional, it sets which providers and facilities are in-network and at what negotiated rates.

PBM

The pharmacy benefit manager administers the Rx benefit: formulary, pricing, rebates, and the pharmacy network. Contract structure drives a large share of plan cost.

Medical Management

Nurse-led utilization review, case management, and disease management. Confirms medical necessity, steers members to appropriate care, and engages high-cost cases early.

Point Solutions

Targeted programs layered on the plan: musculoskeletal, diabetes, behavioral health, fertility, clinical navigation, oncology, and more. Chosen to match the conditions driving the group's spend.

Stop-Loss

The insurance that caps the employer's risk. Specific coverage protects against any one large claimant; aggregate coverage caps total annual claims. This is what makes self-funding safe for small and mid-market employers.

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03 Stop-Loss in Depth

The coverage that makes self-funding workable at your size

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Why Stop-Loss Makes This Work

THE CONCERN EVERY EMPLOYER RAISES

“What if we have a terrible claims year?”

Stop-loss is the answer. It is a separate insurance policy the plan buys to cap how much the employer can ever pay, so a self-funded plan never has unlimited downside.

SPECIFIC (SPEC)

Caps any one person

Protects the plan against a single catastrophic claimant: a cancer course, a NICU stay, a transplant, a high-cost specialty drug.

AGGREGATE (AGG)

Caps the whole group

Protects against a bad year overall, where many ordinary claims add up beyond what the plan expected to pay.

Two layers work together: specific catches the tall individual claim, aggregate catches the broad bad year.

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Specific Stop-Loss: Capping One Claimant



HOW IT WORKS

The specific deductible is the most one claimant can cost the plan.

In this example the spec deductible is $50K. A member runs up a $225K claim. The plan pays the first $50K. Stop-loss reimburses the $175K above it.

Set the deductible lower and premium rises; set it higher and the plan keeps more risk. For 50 to 200 lives, deductibles commonly land in the $50K to $150K range.

WHAT THIS MEANS

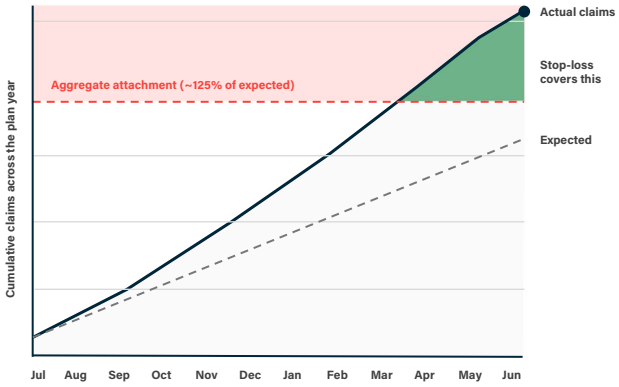
No single person, however sick, can sink the plan. Their cost to the employer stops at the specific deductible.

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Aggregate Stop-Loss: Capping the Year



HOW IT WORKS

The aggregate cap is the most the plan pays in total for the year.

Stop-loss sets an attachment point, usually about 125% of expected claims. If the year runs hot and cumulative claims cross that line, stop-loss covers the excess.

Aggregate accommodation is a valuable add-on: it trues up monthly so the plan is reimbursed during the year, rather than waiting until year-end to collect.

WHAT THIS MEANS

Even a bad year has a ceiling. Between specific and aggregate, the worst case is known before the year begins.

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Trade-Offs & Doing It Well

An honest comparison, and our view of self-funding done right

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Self-Funded vs. Fully Insured: The Trade-Off

WHAT YOU GAIN

- Full claims transparency: you see where the money actually goes
- Direct control over plan design and vendor choices
- Carrier risk margin and state premium tax come out of the cost
- Surplus from a good year stays with the plan
- Freedom to carve out pharmacy, behavioral health, and more

WHAT IT ASKS OF YOU

- **Cash flow varies month to month** *(smoothed by aggregate accommodation)*
- **The plan holds claims risk** *(capped by specific and aggregate stop-loss)*
- **More administrative moving parts** *(the TPA and advisor carry most of the load)*
- **Fiduciary duties the carrier used to absorb** *(ERISA governance and Form 5500)*
- **Rewards engaged leadership** *(the plan performs when leaders look at the data)*

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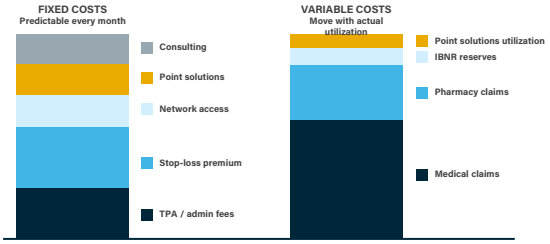
Is Your Group a Fit? Cost & Profile

THE TYPICAL SELF-FUNDED PROFILE

- 50+ employees (some carriers go lower)
- A stable or reasonably predictable population
- Cash flow that can absorb month-to-month variance
- Leadership willing to engage with plan data
- Openness to vendor choices beyond one carrier

None of these is a hard gate. They describe where self-funding tends to perform well; an advisor models the specific group before recommending it.

WHERE THE COST LIVES



Fixed costs are predictable every month. Variable claims are where both the risk and the savings opportunity live, and where active management pays off.

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Our View: Self-Funding Done Properly

Self-funding opens the door. The result comes from how actively the plan manages what it pays for care, not from the funding switch alone.

WHERE MOST BROKERS STOP

Shop the carrier, negotiate the renewal, hand back a rate.

WHERE WE GO

Manage the healthcare expense itself: claims, conditions, and the drivers behind them.

THREE LEVERS THAT MOVE THE NUMBER

Transparent Pharmacy

Pass-through PBM contracting and lowest-net-cost sourcing, so Rx spend reflects real cost rather than hidden spread and retained rebates.

Value-Based Primary Care

Strong primary care access (onsite, near-site, or virtual) that catches issues early and cuts downstream specialist, ER, and imaging costs.

Point Solutions & Navigation

Targeted programs and clinical navigation aimed at the specific conditions driving the plan, paired with active medical management.

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What the First Year Looks Like

DISCOVERY 1 — DESIGN 2 — LAUNCH 3 — ONGOING 4

Look

- Pull census and claims data
- Model the group's risk profile
- Scope stop-loss deductibles
- Confirm self-funding fits

Build

- Select TPA, network, and PBM
- Choose stop-loss terms
- Set plan design and contributions
- Pick point solutions to match drivers

Move

- Contract carriers and vendors
- Communicate to employees
- Run open enrollment
- Hand off to benefits admin

Manage

- Monthly and quarterly claims review
- Watch Rx and high-cost cases
- Refine plan design each year
- Renew stop-loss with protections

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Quick Reference Glossary

TPA	Third-party administrator; runs claims and plan operations.	**PBM**	Pharmacy benefit manager; administers the Rx benefit.
Stop-Loss	Insurance that caps the plan's claims risk.	**Specific**	Stop-loss layer that caps any one claimant.
Aggregate	Stop-loss layer that caps total annual claims.	**IBNR**	Incurred but not reported; claims owed but not yet billed.
Laser	A higher specific deductible on a known high-cost member.	**NNL**	No new lasers; a renewal protection against new lasers.
TLO	Terminal liability option; run-out coverage after termination.	**Incurred / Paid**	The claims window a stop-loss contract covers (e.g. 12/15).
Aggregate Accommodation	Monthly true-up so the plan collects during the year.	**ERISA**	Federal law governing self-funded employer health plans.

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LET'S KEEP THE CONVERSATION GOING

Thank You

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