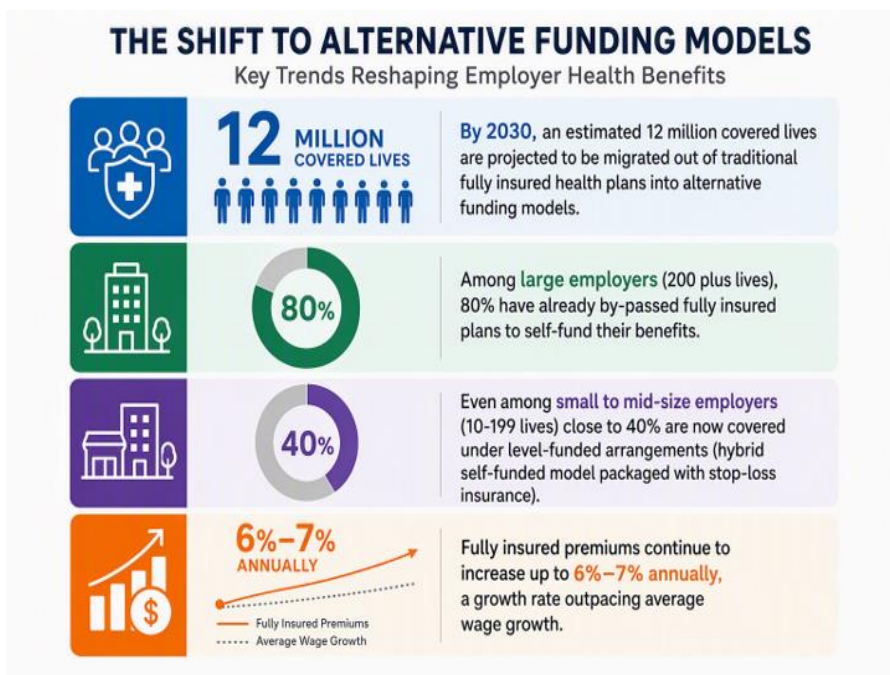


Transitioning from Fully Insured to Self-Funded Health Care

Surging employer health care costs are driving an ever increasing migration away from traditional fully insured plans. Corporate budgets are facing breaking points with healthcare expense climbing 8-9% annually, pushing the average cost per employee past \$17,000. Simply stated, staying fully insured is no longer just an administrative choice; it is a persistent financial drain that absorbs heavy insurer profit margins and hidden fees. Companies of all sizes are facing the reality that continuing to pay skyrocketing, unpredictable premiums to traditional carriers is unsustainable.

As a result, moving from a fully insured health plan to a self-funded model is best viewed as a strategic shift in health care risk management. Fully insured plans provide predictable monthly costs but tie employers and plan sponsors to premium structures shaped by market inflation, carrier margins, administrative loads, and state premium taxes. However, self-funding gives organizations more control over claims costs, plan design, data visibility, and savings opportunities, but it also requires direct management of financial volatility.

As fully insured premiums continue to rise, and as the market has introduced a variety of innovations that support the transition, many employers and plan sponsors are weighing whether to assume more calculated risk through alternative funding models. The decision requires a clear view of both the financial upside and the operational controls needed to manage claims volatility.



The Case for Small Employers

Momentum toward self-funding for small employers has reached a critical tipping point. Historically, self-funding was exclusively for large corporations with deep capital reserves. Today, a combination of market pressures, advanced technological innovation, and regulatory maturity has fundamentally changed the landscape, making the case for smaller employers to jump on the bandwagon.

Regardless of group size, transition is best evaluated across four decision areas: why self-funding creates financial opportunity, how to manage the initial cash-flow bridge, what operating infrastructure must be in place before launch, and how clinical risk management protects the plan after go-live.

Strategic Drivers Behind the Transition

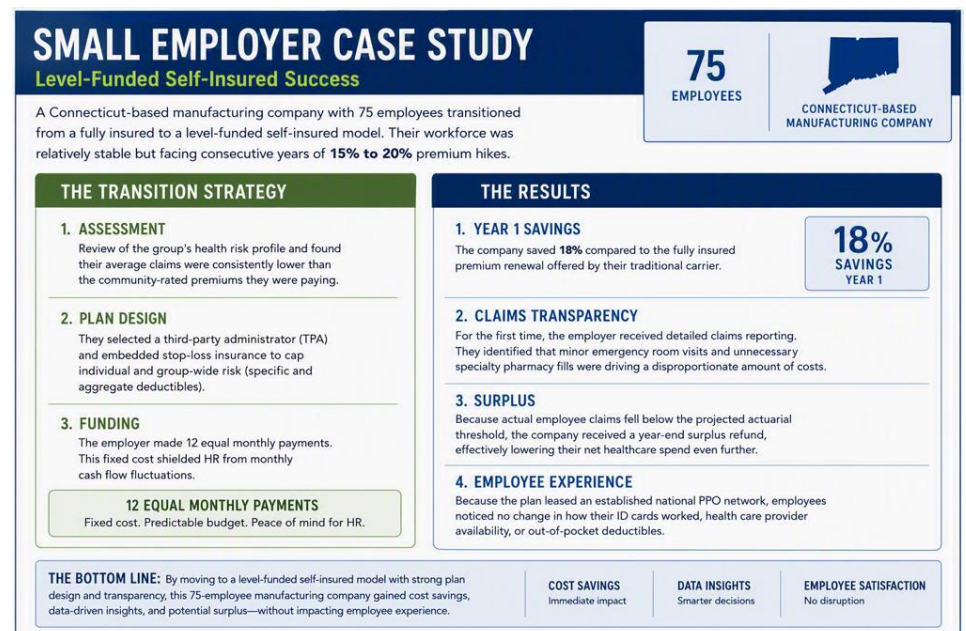
To begin to evaluate whether or not to pursue transitional funding, organizations should first take stock of what the primary objective(s) are relative to leaving the fully insured market.

Fully insured plans charge a fixed monthly premium per employee. These premiums cover expected claims, administrative overhead, state premium taxes, and an insurance carrier risk margin. If claims run low, the carrier retains the surplus as profit.

Self-funding creates value by unbundling the fixed premium into its underlying parts: claims, administration, taxes, and carrier margin.

The main strategic drivers can be summarized as savings from premium-tax exemptions, retention of underwriting surplus in low-claim years, lower fixed carrier costs, improved claims-data visibility, more flexible benefit design, and customized stop-loss protection against catastrophic claims:

- **Elimination of State Premium Taxes:** Fully insured plans are subject to state level insurance premium taxes, typically ranging from 1.5% to 3% of the total premium. Self-funded plans are governed federally by the Employee Retirement Income Security Act (ERISA), exempting the self-insured claims fund from these state levies.
- **Capturing the Risk Margin:** Fully insured carriers price their premiums defensively to guarantee corporate profitability. Self-funded employers keep this underwriting margin for themselves during low-utilization years.
- **Reduce Fixed Costs:** Eliminate standard insurance carrier profit margins, marketing overhead, and administration loading fees.



- **Data Transparency:** Fully insured carriers rarely provide comprehensive, transparent claims data to mid-sized employers due to proprietary underwriting models. *Self-funding grants employers access to itemized utilization data, enabling precise disease management and wellness programming.*
- **Bypass State Mandates:** Opportunity to gain exemption from costly state specific mandates via ERISA exemption.
- **Customize Benefit Design:** Ability to tailor health insurance plan designs more precisely to employee demographics.
- **Manage Volatility Directly:** Secure customized stop-loss insurance coverage to cap financial exposure against catastrophic medical claims.

Transitional Funding Frameworks

The first 90 to 120 days after termination of a fully insured plan create the greatest cash flow risk because the employer begins paying live self-funded claims while the former carrier continues processing incurred but not reported (IBNR) claims from the old policy. Transitional funding arrangements are designed to bridge that timing gap without requiring an excessive day one reserve.

To mitigate this initial cash drain and protect against unexpected claim spikes, health plans and consultants deploy specific transitional funding mechanisms, which include the following:

Split-Funded Structuring

For **larger employers** moving directly into traditional self-funding, a split-funded model reduces upfront cash pressure by pairing a discounted base premium for administration and stop-loss protection with pay-as-claims-go funding. The primary funds designated for healthcare claims remain entirely within the employer's general corporate bank account. The employer only transfers cash to the claims clearing account as claims are actually approved and paid week-by-week, rather than pre-funding a massive reserve on day one.

The following financial arrangements are **well suited for smaller employers** and as mentioned earlier, provide opportunity for these employers to consider self-funding while mitigating risk:

Level-Funded Arrangements

For employers with 25 to 250 enrolled lives, a level-funded plan offers a lower risk path into self-funding: one fixed monthly payment covers administration, stop-loss protection, and a claims account. If claims run below the funded amount, the employer may receive a refund or credit; if claims exceed the pool, stop-loss coverage absorbs the deficit.

The employer pays a fixed monthly fee to a third-party administrator (TPA) or carrier. This payment is actuarially split into three discrete components:

- **Administrative Fees:** Covers network access, utilization review, and claims processing.
- **Stop-Loss Insurance Premiums:** Purchases financial protection against catastrophic claims.
- **Claims Account Contribution:** A budgeted pool used to pay day-to-day medical expenses.

At year end, claims below the funded pool may generate a refund or credit; claims above the pool are absorbed by the integrated stop-loss policy, limiting additional employer liability.

Cash Flow Considerations During the Transition to Self-Funding



Captive Insurance Arrangements (Group Captives)

In a group captive, multiple independent employers share reinsurance risk. Each employer self-funds predictable, lower-dollar claims up to a deductible threshold, while higher dollar claims above that threshold are pooled across the captive.

High-dollar, volatile claims above the local threshold are absorbed and shared among all the member employers in the captive.

Members share underwriting profits and investment income based on captive performance, while the captive purchases commercial stop-loss coverage to protect the pool against catastrophic claims.

Pre-Funding and Capitalized Working Pools

Some organizations pre-fund a dedicated healthcare trust, often a 501(c)(9) VEBA, during a 3-to-6-month ramp-up period while still fully insured. This creates a liquid claims buffer before the self-funded plan goes live and protects general operating capital during the initial claims processing lag.

Operationalizing the Transition Plan

Transitioning smoothly requires a carefully planned timeline spanning at least six months. Moving too quickly risks exposure to compliance gaps, operational disruption, and unmitigated financial risk. General transition steps typically involve the following:

Phase	Key Activity	Description
Feasibility Analysis and Underwriting	Historical Data Extraction	Request 24 to 36 months of aggregate claims history and high cost claimant data from the incumbent fully insured carrier.
	Actuarial Modeling	Engage an independent actuarial firm to run historical claims through a self-funded projection model to determine the optimal budget and expected claims corridor.
	Selecting Specific and Aggregate Limits	A specific stop-loss limit protects against individual catastrophic claims (for example, \$50,000 or \$100,000 per member per year), while aggregate stop-loss limits the company's total annual claim exposure (typically set at 125% of expected claims).
	Contract Term Alignment	Align the stop-loss contract with the transition strategy. Employers often utilize a 12/12 contract (covering claims incurred and paid within the 12-month plan year) to prevent overlap with the old carrier's IBNR run-out period. Alternatively, a 12/15 contract allows an extra three months for trailing claims to clear at the end of the first self-funded year.
Operational Infrastructure Setup	TPA Selection and PPO Network Integration	Contract with a Third-Party Administrator (TPA) to handle claims adjudication, customer service, and network management. Secure access to a competitive Preferred Provider Organization (PPO) network to ensure minimal disruption to employee/doctor relationships.
	Banking and ERISA Plan Documents	Establish a dedicated, segregated banking account solely for healthcare claim transactions. Draft new ERISA compliant Summary Plan Descriptions (SPDs) and plan documents, ensuring the definitions of covered benefits match or strategically improve upon the old fully insured policy.
Employee Open Enrollment and Communication	Managing Expectations	Educate the workforce on the change. Because the underlying network and TPA often mimic traditional insurance brands, employees should experience no change in how they use their insurance cards at pharmacies or hospitals.
	Regulatory Filings	Ensure banking lines are tested, and open enrollment selections are accurately mapped into the TPA's eligibility system.
Go-Live and Beyond: Monitoring and Optimization	Weekly Cash Flow Reviews	Monitor weekly TPA claim drafts against actuarial expectations.
	Run-Out Tracking	Confirm that the previous fully insured carrier is appropriately processing and paying lingering IBNR run out claims without improperly denying coverage to employees.

Clinical Risk Optimization and Underwriting Realities

Building a resilient self-funded program requires looking beyond the baseline financial mechanics. To protect the newly formed health benefit trust, organizations need to make sure they have the expertise (in-house or contracted out) to conduct advanced data underwriting, as well as the ability to use those insights for the development and deployment of targeted clinical cost-containment programs.

Managing High Cost Claimants During Underwriting

The financial stability of a self-funded plan hinges heavily on the precision of the initial underwriting phase. When analyzing the 24 to 36 months of historical claims data extracted from the previous fully insured carrier, the primary focus should be identifying and tracking **high cost claimants (HCCs)**—individuals whose ongoing medical needs could breach the corporate specific stop-loss deductible.

It is useful to engage clinical expertise to help develop approaches for tracking and managing high cost claimants, both in terms of managing existing and identifying potential new claimants who might benefit from more focused mitigation, such as targeted disease management and ability to flex benefits accordingly. Previous articles for reference: [The Rise of Direct Contracting in Employer-Sponsored Healthcare](#), [The Centrality of Utilization Management](#)

Value-Based Care and Clinical Cost Containment

In a fully insured model, carriers manage costs defensively by restricting networks or requiring extensive prior authorizations. In a self-funded environment, the employer has the flexibility to integrate **Value-Based Care (VBC)** models and active clinical management directly into the plan design to lower costs without compromising care quality.

- **Direct Contracting and Accountable Care Organizations (ACOs):** Self-funded employers can bypass traditional insurance carrier networks and contract directly with regional health systems or Accountable Care Organizations (ACOs). Under a direct contracting framework, the employer and the healthcare provider agree on flat rate, bundled payments for specific high cost episodes of care. This eliminates fee-for-service cost volatility and guarantees predictable, pre-negotiated pricing.
- **Advanced Pharmacy Benefit Management (PBM):** Specialty medications represent a primary driver of catastrophic health plan claims. Traditional fully insured plans often bundle pharmacy benefits into the master premium, keeping the manufacturer rebates for themselves. A transitioning employer should consider unbundling their pharmacy program by contracting with a **transparent or pass-through Pharmacy Benefit Manager (PBM)**. This structure ensures that 100% of drug manufacturer rebates are sent directly back to the employer's health plan trust.

Conclusion

Transitioning from a fully insured health plan to a self-funded framework is an effective strategy for controlling runaway corporate healthcare costs. While the financial benefits—such as ERISA exemptions, tax savings, and surplus capture—are clear, managing the transitional phase requires careful planning. By utilizing level-funded bridges, selecting precise stop-loss contract structures, establishing value-based care pathways, and maintaining ERISA governance, organizations can successfully navigate the initial transition phase and build a sustainable, cost effective corporate benefits program.