BOARD MEETING AGENDA
Wednesday, August 14, 2026 – 11:30 a.m.
2703 NE 14th Street, Ocala, FL 34470

Join Zoom Meeting: https://us02web.zoom.us/j/86297313082
Conference Line: 1 646 558 8656 Meeting ID: 862 9731 3082

Call to Order		A. Proctor
Roll Call		C. Schnettler
Public Comment		A. Proctor

DISCUSSION ITEMS

Self-Insurance Agency Marsh McClennan	Pages 2 - 43	Jamie Hagar Chase Bowman

PROJECT UPDATES
None

MATTERS FROM THE FLOOR

ADJOURNMENT

OUR VISION STATEMENT

To be known as the number one workforce resource in the state of Florida by providing constructive tools and professional supportive services that are reflected in the quality of our job candidates and meet the needs of the business community.

MarshMcLennan Agency

CareerSource Citrus Levy Marion

RESPONSE TO REQUEST FOR INFORMATION

Self-Insurance Exploration

Submitted by

Marsh McLennan Agency LLC

July 24, 2026

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Submitted electronically to Sandra Crawford (scrawford@careersourceclm.com) in response to CLM's Request for Information: Self-Insurance Exploration. Firm qualifications and presentation information are provided under separate cover.

Executive Summary

CareerSource Citrus Levy Marion (CLM) is evaluating alternatives to its current fully insured health plan. Marsh McLennan Agency (MMA) submits this response to give the Board an objective, data-informed basis for that evaluation.

CLM's most recent renewal carried an initial proposed increase of approximately 27%, reduced to about 7.8% only after adopting higher deductibles and increased prescription cost sharing. That pattern signals the current arrangement is shifting cost to employees rather than giving CLM real tools to manage it. It is the central reason a structured, side-by-side look at self-insurance, level-funding, and an improved fully insured approach is warranted now.

Healthcare funding sits on a spectrum: fully insured (fixed premium, insurer bears risk), level-funded (fixed payment with a possible year-end refund), and self-funded (variable cost, employer bears risk and keeps savings). Where CLM belongs on that spectrum depends on administrative capacity (self-funding needs roughly 28 to 42 HR hours per month versus 10 to 17 for fully insured), claims data access (CLM currently receives none from Florida Blue), its multi-option HMO/PPO/HSA population and broad pay range, and the Board's tolerance for cost variability.

RECOMMENDED ACTION FOR THE BOARD
MMA recommends the Board authorize a structured feasibility assessment comparing fully insured, level-funded, and self-insured approaches. That assessment should weigh claims and renewal history, employee affordability, provider network continuity, stop-loss needs, and long-term cost stability, and would inform a subsequent RFP for professional services.

The sections below respond, in order, to each topic identified in the Scope of Requested Information in CLM's RFI. MMA's firm qualifications and presentation information are provided as a separate, supplemental document.

Response to Scope of Requested Information

The six sections that follow directly address the topics identified in CLM's RFI, in the order requested, with a brief “Consideration for CLM” note at the close of each section highlighting how the general guidance applies to CLM's specific circumstances.

1. Self-Insurance Structure and Requirements

A self-insured health plan can give an employer more flexibility, better visibility into cost drivers, and greater control over plan design than a traditional fully insured arrangement. Rather than paying a fixed premium to an insurance carrier, the employer pays for healthcare claims as they occur, using organizational funds, usually paired with stop-loss protection to limit exposure to large or unexpected losses.

A self-insured structure for an organization of CLM's size would generally include:

Component	Role
Governance	Board and management decision-making oversight of the plan
TPA or ASO platform	Claims administration, eligibility, member service, and reporting
Provider network	Access to a stable, competitive network of physicians and facilities
Pharmacy benefits manager	Formulary management, rebate administration, and specialty pharmacy oversight

Component	Role
Stop-loss insurance	Specific and, where appropriate, aggregate coverage
Funding and reserve strategy	Addresses claims volatility and incurred-but-not-reported liabilities
Compliance support	Covers applicable legal, regulatory, and fiduciary requirements
Analytics and reporting	Ongoing performance reporting to support decision-making

Self-funding can also provide more direct access to plan performance information, including claims, utilization, and cost drivers. For CLM, this is especially relevant because the organization does not currently receive claims data under its existing arrangement. Based on the benefit materials reviewed, CLM currently operates under a fully insured arrangement with Florida Blue and offers a mix of HMO, PPO, and HSA-compatible plan options, which suggests employee choice and affordability are already important priorities for the organization.

Whether self-insurance is appropriate for CLM will depend on employee population size and stability, dependent enrollment, financial tolerance for variability, organizational risk appetite, and the extent to which credible claims information can be obtained from current carriers and vendors. A move to self-insurance would also increase CLM's direct oversight responsibilities for compliance and administration: the employer takes a more active role in overseeing matters such as ERISA, HIPAA privacy and security, COBRA administration, and certain transparency and disclosure obligations that a carrier currently handles.

Governance takes on a bigger role under this model. The Board and management would assume active fiduciary responsibility for the health plan, including budget approval, vendor selection, and policy decisions, typically through a governance committee or by designating existing leadership to review vendor reporting and approve material plan or funding changes.

CONSIDERATION FOR CLM
Administrative capacity and vendor support should be considered alongside financial analysis. It may also be appropriate to evaluate level-funded arrangements alongside full self-insurance and continued full insurance, rather than treating this as a binary decision.

2. Risk Mitigation Strategies

Risk mitigation is a central consideration in any self-insured arrangement. A prudent strategy combines financial protection, disciplined governance, and active plan management. Key measures generally include:

- **Specific stop-loss insurance:** protects against high-cost claims from any one individual above a selected deductible
- **Aggregate stop-loss insurance:** caps total annual claims exposure across the group, where appropriate
- **Reserve planning and funding discipline:** addresses timing differences in claims payments and provides financial stability
- **Claims forecasting and scenario modeling:** uses credible experience, market data, and vendor information to set realistic budgets
- **Clinical and utilization management:** targets chronic conditions and high-cost claimants before costs escalate
- **Pharmacy management strategies:** focuses on specialty drug utilization and trend management
- **Vendor performance oversight:** supported by reporting, service standards, and periodic review
- **Monthly aggregate accommodation:** a stop-loss feature offered by some carriers for earlier reimbursement of high claim levels, helping manage cash flow

Catastrophic claims, such as a premature birth requiring NICU care, a complex cancer diagnosis, or a specialty drug costing hundreds of thousands of dollars annually, illustrate why stop-loss coverage is treated as essential rather than optional in a self-insured arrangement, regardless of group size.

Risk mitigation may also include alternative risk-sharing approaches, such as level-funded arrangements or captive structures, depending on group size, financial objectives, and risk tolerance. These approaches can allow an employer to move toward self-funding while retaining a greater degree of cost predictability or shared risk than a fully self-insured model. Stop-loss deductible levels and coverage terms are generally set based on group size, historical claims experience, and financial risk tolerance, and are revisited at each renewal as claims experience develops.

CONSIDERATION FOR CLM

CLM's recent renewal experience makes this analysis particularly important: an initial proposed increase of approximately 27% was ultimately reduced to about 7.8% through alternate plan options that included higher deductibles and higher prescription cost sharing. That pattern is exactly why it matters to know what information can realistically be obtained to support a self-insurance review. If detailed claims data is not currently available, the feasibility analysis may need to begin with a formal data request to Florida Blue and other vendors, relying initially on enrollment, premium, and plan information. Leadership's tolerance for year-to-year cost volatility should be an important part of this review.

3. Provider Network Continuity

Provider continuity is often one of the most significant employee considerations in evaluating a move from a fully insured plan to a self-insured model. Self-insurance does not necessarily require a material change in provider access, however. In many cases, network continuity can be preserved through the selection of an appropriate TPA or ASO administrator, and transition-of-care protections can carry members through active treatment without a disruptive network change. Strategies to support continuity include:

- Evaluating administrators that offer the same or substantially similar provider networks currently used by employees
- Conducting a provider disruption analysis to compare current physicians, hospitals, and facilities against proposed network options
- Reviewing network access by geography and provider type
- Identifying transition-of-care protections for members undergoing active treatment
- Implementing a proactive communication strategy to support employee understanding and confidence during any transition

Depending on the funding model under consideration, CLM may also wish to evaluate whether network strategy should remain largely unchanged or whether narrower, alternative, or value-based network approaches should be reviewed for savings opportunities alongside employee disruption considerations. A clear communication plan, explaining what is changing (the funding mechanism and administrator) and what is not (in most cases, the provider network and plan options), helps limit employee confusion during the transition. FAQs, ID card transition guidance, and a dedicated point of contact for questions during open enrollment are typical components of a well-managed communication plan.

CONSIDERATION FOR CLM

Because CLM currently offers multiple Florida Blue options, preserving network familiarity where feasible may be an important factor in limiting disruption and maintaining employee confidence. Provider network analysis would likely be an important component of any feasibility review so CLM can weigh both financial impact and employee experience before making a decision.

4. Third-Party Administrator (TPA) and Pharmacy Benefits Manager (PBM) Functions

Within a self-insured model, the TPA and PBM are central to day-to-day operations, member experience, and cost management. CLM retains ultimate responsibility and fiduciary duty in all cases.

Role	Key Functions
Third-party administrator	Claims processing and adjudication; eligibility and enrollment management; provider network access; member service support; compliance reporting for ERISA, HIPAA, ACA, and COBRA; analytics and cost trend tracking
Pharmacy benefits manager	Retail, mail, and specialty pharmacy network management; formulary administration; prior authorization and utilization controls; rebate negotiation and financial reporting; member service support

Key TPA selection considerations generally include network strength, service model, reporting capabilities, implementation support, clinical resources, data transparency, financial stability, and contractual performance guarantees. Implementation with a new TPA usually begins 90 to 120 days ahead of the effective date, allowing time for data feed testing, staff training, and member communication before go-live.

Because prescription drug spending is often a significant cost driver, PBM evaluation should weigh pricing transparency and rebate treatment just as heavily as formulary and clinical management capabilities. Some TPAs bundle pharmacy services internally, while others work with independent PBMs through a carve-out arrangement; carve-out arrangements tend to offer greater pricing transparency and negotiating leverage, while bundled arrangements can simplify administration and member experience.

CONSIDERATION FOR CLM
Given the renewal pressure reflected in CLM's current materials, PBM transparency, rebate treatment, specialty pharmacy management, and access to actionable utilization data deserve particular attention. Both integrated and carve-out PBM approaches are worth evaluating to find the most effective balance of transparency, operational simplicity, employee experience, and financial performance.

5. Data Requirements

A reliable self-insurance assessment depends on complete and credible information. To evaluate feasibility and develop plan recommendations, the following data is generally requested:

Category	Data Needed
Population and enrollment	Employee census and dependent enrollment; age, gender, and geographic distribution; enrollment by plan option and tier; compensation bands
Financial	Current and historical premium rates; contribution strategy; monthly enrollment and premium history; administrative and fixed fees
Claims and utilization	Medical and pharmacy claims experience (24 to 36 months recommended); large claimant reporting; diagnosis or condition prevalence, where available
Plan and vendor	Current plan documents and eligibility rules; carrier, TPA, PBM, and network arrangements; renewal and underwriting history; ancillary and voluntary benefits
Strategic	Budget objectives and risk tolerance; implementation timing; priorities related to affordability, flexibility, and long-term sustainability

While detailed claims transparency is often one of the advantages of self-funding, CLM does not currently receive claims data under its existing arrangement. As a result, an early step in any feasibility assessment would be to determine what information can be obtained from Florida Blue and other vendors. If detailed claims information is limited, the analysis may need to rely more heavily on premium history, enrollment, plan design, and other available information until more detailed experience can be secured.

CONSIDERATION FOR CLM
The salary range information reviewed suggests a broad compensation spread across CLM's workforce. Contribution affordability should therefore be an important part of any analysis, particularly to understand how future contribution strategies could affect lower-paid employees differently than higher-paid employees. Once validated, this information can be used to model expected claims, fixed costs, reserve requirements, stop-loss options, and plan design scenarios.

6. Plan Design Options

A self-insured arrangement can provide greater flexibility in benefit design, allowing CLM to align coverage strategy more closely with organizational goals and employee needs. Design flexibility should be evaluated alongside financial modeling and workforce impact. In addition to traditional plan design decisions, self-funded arrangements may allow greater flexibility in vendor selection, targeted care programs, and employee navigation strategies, including condition management, enhanced mental health support, and features designed to guide members toward higher-value care.

Potential plan design options may include:

- PPO plan structures and high-deductible health plans compatible with Health Savings Accounts
- Alternative deductible, coinsurance, and out-of-pocket maximum designs
- Tailored office visit, urgent care, and emergency room cost-sharing strategies
- Employer and employee contribution alternatives, including percentage-of-salary or continued fixed-dollar approaches
- Preventive care coverage and wellness incentive programs
- Chronic condition management and care navigation support
- Pharmacy formulary tiering and specialty drug strategies
- Network options designed to balance access and cost efficiency, including value-based or reference-based pricing

Under a self-funded structure, employee wellbeing shifts from a cultural initiative to a direct financial strategy, since favorable outcomes accrue as savings CLM keeps rather than a discount an insurer might otherwise retain. In a fully insured arrangement, poor health trends surface later as higher renewal premiums; in a self-funded arrangement, they appear directly in claims experience in real time.

CONSIDERATION FOR CLM
CLM currently maintains multiple medical plan options and a fixed employer contribution approach. Any future design review should consider whether that structure remains appropriate or whether contribution strategy should be revisited as part of a broader funding discussion. For organizations seeking a more gradual transition, level-funded arrangements or other intermediate structures are also worth reviewing alongside fully insured and fully self-insured options.

Closing Recommendation

Taken together, the sections above point to a consistent picture. CLM's most recent renewal, an initial proposed increase of approximately 27% reduced to about 7.8% only through higher deductibles and increased prescription cost sharing, suggests the current fully insured arrangement is managing cost pressure by shifting it to employees rather than giving CLM the tools to address it directly. At the same time, CLM does not currently receive claims data from Florida Blue, has a broad compensation range across its workforce, and would need to build meaningfully more internal administrative capacity to operate a self-insured plan. None of this rules out self-insurance, but it does mean CLM is not yet in a position to make that decision with confidence.

Rather than treating this as a single up-or-down choice, MMA recommends a phased path that builds the data and experience CLM needs before committing to full financial risk:

Phase	Focus
Phase 1: Feasibility and data assessment	Submit a formal data request to Florida Blue, model fully insured, level-funded, and self-insured scenarios side by side using whatever claims and premium history can be obtained, and assess CLM's administrative readiness and risk tolerance.
Phase 2: Level-funding as a bridge	If feasibility supports it, transition to a level-funded arrangement before moving to full self-insurance. This gives CLM real claims transparency and the potential for a year-end refund, while keeping costs largely predictable and limiting CLM's direct risk exposure.
Phase 3: Reassess and transition	After 12 to 24 months of level-funded experience, reassess using CLM's own accumulated claims data. Move to full self-insurance if the data supports it, remain level-funded if that balance of risk and predictability continues to fit, or return to a strengthened fully insured arrangement with better vendor accountability if the numbers do not support a change.

This approach lets CLM build toward self-insurance deliberately, evaluating level-funding and other intermediate options along the way rather than committing to full financial risk before the underlying data and administrative readiness are in place. MMA welcomes the opportunity to guide the Board through each phase of this evaluation, starting with the feasibility assessment outlined in the Executive Summary.

FIRM QUALIFICATIONS AND PRESENTATION INFORMATION

Supplemental response to CLM's RFI: Self-Insurance Exploration

Submitted by Marsh McLennan Agency LLC to CareerSource Citrus Levy Marion | July 24, 2026

1. Company Background and Principals

Marsh McLennan Agency LLC (MMA) provides business insurance, employee health & benefits, retirement & wealth, and private client insurance solutions to organizations and individuals across the United States and Canada. MMA combines the personalized service model of a local consultant with the global resources of Marsh McLennan (NYSE: MMC), the world's leading professional services firm in risk, strategy, and people, operating through more than 300 offices and approximately 15,000 colleagues.

This response is led by Jamie Hagar, Vice President, Employee Health & Benefits, supported by MMA's health and benefits consulting team and the specialized Centers of Excellence described below.

OUR APPROACH

MMA positions itself as a strategic advisor, not a vendor pitching a predetermined solution. We model fully insured, level-funded, and self-insured options fairly, using CLM-specific data wherever available, and recommend the approach best suited to CLM's circumstances. That could include continued full insurance with stronger vendor accountability, if that is what the analysis supports.

2. Experience Serving Non-Profit and Public-Sector Organizations

MMA has worked with various non-profit organizations to evaluate healthcare funding strategies and support implementation of alternative funding approaches. Through that experience, we have arrived at a consistent principle: the appropriate funding model is organization-specific, shaped by financial stability, risk tolerance, administrative capacity, and strategic priorities. There is no universal answer that fits every organization, and we do not begin an engagement with a predetermined recommendation.

To give the Board a fuller picture of that experience, we have included an overview of MMA's EHB Human Service and Non-Profit practice as a supplemental document to this response. It outlines our core services and the specialized focus our team brings to organizations operating in the non-profit and public-sector space, the same focus we would bring to this engagement with CLM.

For organizations in CLM's position, our evaluation approach generally covers:

- **Financial modeling:** comparative analysis of fully insured, level-funded, and self-insured scenarios using organization-specific projections and assumptions
- **Readiness assessment:** evaluation of claims data availability, reserve requirements, administrative resources, and risk tolerance
- **Vendor evaluation:** identification and assessment of TPA, PBM, and stop-loss carriers appropriate for organizations of similar size and structure
- **Plan design analysis:** modeling of alternative benefit designs and contribution strategies within each funding approach

- **Implementation planning:** a transition roadmap covering governance, compliance, and performance management
- **Stakeholder communication:** a strategy for explaining funding changes and maintaining employee confidence through the transition

MMA's Centers of Excellence support this work directly: RX Solutions, our Pharmacy Center for PBM selection and rebate optimization, our Stop-Loss Center of Excellence for coverage structuring, our PATH (Predictive Analytics for Total Health) platform for claims forecasting even where carrier data is limited, and our Compliance Center of Excellence for governance and regulatory support.

3. Presentation Information

MMA welcomes the opportunity to present this information directly to the CLM Board and senior management, and to answer questions as the Board works toward a subsequent RFP for professional services.

Element	Details
Duration	60 to 90 minutes, including Q&A
Audience	CLM Board of Directors and senior management
Key topics	Funding model comparison, financial analysis approach, CLM-specific considerations, and a decision framework for next steps
Format	Interactive presentation with comparative analysis and scenario-based decision tools
Availability	August and/or September 2026, per CLM's anticipated scheduling

4. Venue Preference

MMA recommends an in-person presentation given the strategic importance of this decision. While we are fully equipped to present via Zoom, meeting in person supports real-time discussion of financial trade-offs, a thorough understanding of plan design and funding options, and the relationship foundation that supports implementation if CLM moves forward. We can present at CLM's preferred Florida location or an MMA office, with virtual follow-up sessions available as needed.

5. Printed Materials on Self-Insurance

MMA is providing the following educational materials developed by our firm, submitted alongside this response:

- **Self-Funding 101, our guide to funding strategies for employee benefit plans:** an overview of the healthcare funding spectrum, including benefits, risks, compliance requirements, and key vendor roles.
- **Self-Funded Readiness Guide:** a structured workbook for evaluating organizational readiness across financial, administrative, and strategic dimensions, including a section-by-section tool the Board and management can use collaboratively to assess CLM's specific readiness for a funding transition.

MMA is prepared to support CLM through every phase of this evaluation and welcomes the opportunity to discuss this submission further at the Board's convenience.

MarshMcLennan Agency

Self-Funding 101

A guide to funding strategies for employee benefit plans

Your future is limitless.℠

A business of Marsh McLennan

Providing health benefits is one of the largest expenses for employers, and rising costs continue to put pressure on organizations of all sizes.

Many businesses are exploring alternative ways to fund employee health plans beyond traditional, fully insured arrangements. Self-funding offers an opportunity for employers to increase their control of healthcare costs, gain transparency into claims spending, and design a benefits program that more closely meets their workforce's unique needs. According to the Kaiser Family Foundation, the percentage of U.S. workers covered by self-funded plans rose from 54% in 2004 to 63% in 2024, highlighting its growing adoption. However, self-funding isn't a one-size-fits-all solution. This guide will walk you through the basics of self-funding, its benefits and risks, alternative funding arrangements, compliance considerations, and the key partners involved in a self-funded plan.

Contents

Understanding self-funding and its role in benefits strategy

In a self-funded (or self-insured) health plan, the employer assumes financial responsibility for providing healthcare benefits to employees.

Instead of paying fixed premiums to an insurance carrier (as in a fully insured plan), the employer pays for healthcare claims as they occur, using the company's own funds. Often, a third-party administrator (TPA) is hired to process claims, access provider networks, and handle administrative tasks on the employer's behalf. Employers also typically purchase stop-loss insurance to cap their liability for large claims; this insurance reimburses the employer for claims exceeding a certain threshold. **In essence, a self-funded plan makes the employer the "insurer" for its group health plan, with flexibility to design benefits but also responsibility for claim costs.**

The difference between self-funding and fully insured plans

In a **fully insured plan**, an employer pays a fixed monthly premium to an insurance carrier, which assumes the financial risk for covering employee healthcare claims. The insurer sets the rates based on expected claims, administrative costs, and profit margins. If actual claims are lower than anticipated, the insurance carrier retains the extra funds. If claims exceed projections, the carrier absorbs the costs, which can result in higher renewal rates for the employer the following year.

In contrast, a **self-funded plan** allows employers to pay for claims directly as they are incurred, rather than paying a fixed premium. Employers take on financial risk but also have the potential to retain cost savings if claims are lower than expected. This model provides flexibility in plan design and allows employers to access claims data for better cost management.

Benefits and risks of self-funding

The benefits

Self-funded health plans offer several compelling benefits for employers, primarily centered on cost control, flexibility, and transparency.

Potential cost savings

The primary advantage is the opportunity to save money. In a self-funded plan, employers do not pay the insurance carrier's profit margin, risk charges, or certain taxes, so those costs are eliminated. Essentially, you pay for what you use. If your group has lower-than-expected claims, the savings accrue directly to the employer rather than to an insurer. Because they are subject to ERISA, which preempts state laws, self-funded groups can also avoid state premium taxes and some ACA insurer fees. Over time, assuming stable or improving health trends, these factors can lead to significant cost reductions for the employer.

One of the key reasons employers choose self-funding is the opportunity to "win" by directly benefiting from lower-than-expected healthcare claims. In a fully insured scenario, any year with low claims is gain for the insurance company. In a self-funded scenario, any good year is a win for the employer's budget—those funds remain or can be used to bolster reserves or invest elsewhere. Employers can gain control over this opportunity through customized plan design, detailed claims data insights, and strategic vendor partnerships, enabling proactive cost management and maximizing potential savings.

Avoid “trend-on-trend” premium hikes

Insurers often increase premiums annually as a matter of course to account for medical inflation and other factors, sometimes beyond what a single employer’s experience warrants. Self-funded plans, by contrast, are rated mostly on actual claims. If your claims are flat for three years, you aren’t forced to pay 10% more each year just because the market is trending up. This can break the cycle of ever-increasing costs. Some years will be higher, some lower, but you’re no longer automatically compounding increases.

Flexibility in plan design

Self-funding gives employers more freedom to tailor their health plans. You can design coverage to meet the specific needs of your workforce—for example, customizing deductibles, copays, covered services, and wellness incentives, rather than being placed in a “one-size-fits-all” policy. Employers can choose preferred providers or networks, carve out or enhance certain benefits (like mental health programs), and exclude benefits that aren’t needed (subject to federal requirements). This flexibility helps align the plan more closely with company culture and employee needs and can also target cost drivers.

Transparency and data access

Self-funded plans provide full claims transparency. Employers receive detailed reports on healthcare utilization, claims paid, high-cost conditions, prescription drug spending, and more. This data is extremely beneficial for making informed decisions. You can identify trends (e.g., an increase in diabetes or orthopedic surgeries) and then implement targeted interventions such as disease management or alternative care programs. In a fully insured arrangement, carriers can provide high-level data, delayed data, or no data at all. With self-funding, since the plan is essentially yours, you are entitled to all the data (subject to HIPAA privacy safeguards).

Additionally, with new Transparency in Coverage regulations, employers have unprecedented visibility into healthcare pricing and quality data, enabling them to strategically guide employees toward high-value providers and facilities. Employers can use these data insights to identify significant price variations for the same services within their geographic area and then proactively incentivize employees to choose more cost-effective, high-quality care options through plan design, reduced copays, or concierge navigation programs.

Why data tranparency matters

Identify cost drivers:

Employers can see which types of claims are contributing to overall costs and take steps to mitigate unnecessary spending.

Tailor benefits programs:

Companies can adjust deductibles, copays, and provider networks based on actual employee utilization.

Improve employee health management:

Data insights help companies implement targeted wellness and disease management programs to reduce long-term costs.

Control over vendors and program selections

In a self-funded plan, the employer can select service providers for various plan functions that best fit their needs—such as choosing a TPA or Administrative Services Organization (ASO) partner, a Pharmacy Benefit Manager (PBM) for prescriptions, care management vendors, stop-loss carriers, wellness program providers, and more. You are not tied to one insurance company's offerings. This means you can shop for competitive administrative fees and pick partners aligned with your objectives (e.g., a TPA that provides superior customer service or a network that offers better discounts in your key locations). If a vendor underperforms, you can replace them without having to change your entire insurance plan.

The risks

Despite the advantages, self-funding is not without risks. Employers must carefully weigh these risks and take steps to mitigate them.

Cost volatility and uncertainty

Unlike the predictability of a fixed insurance premium, self-funded plan costs can fluctuate from month to month and year to year depending on claims. A year with several large claims, such as multiple high-cost surgeries or cancer treatment, can cause your healthcare spending to spike unexpectedly. This uncertainty can make budgeting a challenge. Employers need to be prepared for the possibility that healthcare costs could exceed projections in any given year.

Smaller employers may find this volatility stressful compared to the stability of a premium. To manage this, it's crucial to set aside adequate reserves and use actuarial forecasts when setting budgets. Many self-funded employers base their contributions on an expected claims costs (often using professional actuarial analysis) plus a margin for fluctuation. If actual claims come in below expectations, great—you save the difference; if they come in higher, you'll need to cover the overrun (though stop-loss insurance can limit the extreme high end).

Catastrophic claims risk

With self-funding, the employer is responsible for paying all eligible claims, no matter how large. This means exposure to catastrophic claims—for example, a premature baby in the NICU, a cancer case with chemo and surgery, or a specialty drug that costs hundreds of thousands of dollars annually. Any such claim can significantly impact the plan's finances.

Stop-loss insurance is an essential tool to mitigate this risk. By purchasing stop-loss coverage, the employer caps its liability on any single high-cost individual claim (specific stop-loss) and caps total claim costs for the year (aggregate stop-loss) to guard against a high frequency of claims. While stop-loss premiums themselves are a fixed cost (and add to your expenses), they provide a safety net so that the employer isn't on the hook beyond a certain threshold.

Some employers choose to buy monthly aggregate accommodation, a stop-loss insurance feature that provides early reimbursement for high overall claim levels, rather than waiting until the end of the policy year. This helps employers manage cash flow by covering unexpected spikes in claims expenses. Some policies also include accelerated or immediate reimbursement, which allows employers to receive stop-loss payments quickly after a large claim. Not all stop-loss policies include this provision, so it's important to review contract terms when considering a stop-loss policy.

Administrative and compliance burden

When self-funding, the administrative responsibilities shift from the insurance carrier to the employer (and any vendors the employer hires). This means the employer—often through an HR/benefits team or a hired TPA—must handle tasks such as enrolling participants, processing or auditing claims, contracting with providers or networks, and managing customer service for employees. There are also numerous compliance requirements: creating and distributing plan documents (Plan Document and Summary Plan Description), filing required reports (like Form 5500 for larger plans), complying with ERISA fiduciary standards, handling HIPAA privacy and security for health data, and more. For a smaller company without a dedicated benefits staff, this can be daunting. Mistakes in compliance, like not covering a mandated benefit or experiencing a privacy breach, could lead to penalties. Many employers mitigate this by outsourcing to experienced TPAs or ASO services from insurers, but they still must oversee those administrators.

Essentially, self-funding requires a higher level of involvement—the employer is now operating a health plan, which comes with legal duties. This administrative burden is why some say self-funding isn't for everyone, especially very small businesses with limited HR resources.

Self-funding may not suit every organization. Small employers may find the risk levels and administrative effort too high relative to their resources. Additionally, the health profile of the employee group matters. If your workforce has many older workers or individuals with serious health conditions, a fully insured community-rated plan might actually be cheaper because the risk is spread over a larger pool. Therefore, companies with very high-cost populations or unstable, unpredictable claims might think twice about self-funding unless they pair it with robust risk mitigation—like joining a larger risk pool or captive.

Despite these risks, many self-funded health plans can be effectively managed. The use of stop-loss insurance, risk-pooling arrangements—such as captives or consortiums and professional administrators can blunt the downsides of self-funding. Additionally, strategies such as setting up wellness programs, care management for chronic conditions, and using data analytics to intervene early can reduce claims volatility.

Risk tolerance is key. Leadership must be comfortable with variability and possible higher spend years. If a company operates on thin margins or cannot afford cost swings, it may prefer the certainty of insured premiums. It's crucial to evaluate your financial stability and risk tolerance before self-funding.

Compliance considerations for self-funded plans

When an employer moves to a self-funded health plan, the regulatory landscape shifts primarily to federal law, and the employer takes on new compliance duties. It's crucial for employers to understand these obligations to avoid penalties and ensure the plan is run legally and efficiently.

Key compliance areas

ERISA compliance

Group health plans maintained by private employers are generally governed by the Employee Retirement Income Security Act of 1974 (ERISA), which sets standards for plan fiduciaries, reporting, disclosure, and claims procedures. Although ERISA applies to both fully insured and self-funded plans, the carrier will be directly liable for many of the compliance responsibilities if the plan is fully insured. Self-funded plan sponsors can delegate many of those obligations to TPAs, PBMs and other vendors, but remain ultimately liable for any compliance failures. Vendor contracts should be reviewed carefully and drafted to include indemnification protections for the employer. If a trust is established to fund the plan, additional compliance responsibilities will apply.

One of the biggest advantages to self-funding is that ERISA exempts self-funded plans from most state insurance laws, although some laws that apply to the employer (rather than the group health plan) or to vendors (such as PBMs) may have an impact on benefits administration. Note: Self-funded plans sponsored by a governmental entity and church plans are not subject to ERISA, and thus not exempt from many state insurance laws.

ACA regulations

Employers have a great deal of flexibility in designing self-funded plans but will need to keep in mind that Affordable Care Act (ACA) group health plan mandates still apply (though the plan will be exempt from some provisions that specifically target insured plans).

An employer sponsoring a self-funded medical plan is considered an issuer of coverage and must report information on covered individuals each year. Smaller employers may report via Form 1095-B, while applicable large employers may include that information on Part III of Form 1095-C. Self-funded plans must also pay the ACA's Patient-Centered Outcomes Research Institute fee (PCORI) annually, which is a nominal fee used to fund comparative effectiveness research. This is done via IRS Form 720, due July 31 each year.

HIPAA compliance

In a fully insured plan, most Health Insurance Portability and Accountability Act (HIPAA) privacy obligations fall primarily on the insurance carrier, significantly reducing the employer's compliance burden. However, in a self-funded arrangement, the group health plan itself is the "covered entity" and the employer must ensure that the plan complies with all of HIPAA's requirements. Those include safeguarding protected health information, implementing comprehensive administrative, technical, and physical security measures, creating a Notice of Privacy Practices and required policies and procedures, training staff on privacy policies, and managing breach notifications if incidents occur.

Because self-funded employers may handle more sensitive employee health information directly or through contracted vendors, they often set up a privacy firewall so that only certain HR staff or the TPA have access to individual medical information. The health plan must have Business Associate agreements in place with any service providers to the plan that may access protected health information. The plan also needs to designate a HIPAA Privacy and Security Officer to oversee compliance with applicable regulations.

COBRA administration

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), self-funded employers generally have the same obligations as fully insured employers, but self-funded employers typically assume greater direct responsibility for compliance and administration (including notifying employees and dependents of their COBRA rights, managing COBRA enrollment, billing, and collecting premiums, and ensuring ongoing compliance with COBRA duration and termination rules). Self-funded employers may handle these responsibilities directly or through a TPA, whereas fully insured employers might be able to rely on their insurance carrier to assist with COBRA administration. Self-funded employers must also determine the applicable COBRA premium.

No Suprises Act and Transparency

The Transparency in Coverage rules contain numerous disclosure requirements, such as the requirement to post machine readable files (MRFs) and the requirement for an internet-based price comparison tool. The Consolidated Appropriations Act (CAA) also added reporting and disclosure requirements including the No Surprises Act Disclosure Notice Regarding Patient Protections Against Surprise Billing, reporting on pharmacy benefits and drug costs and air ambulance reporting requirements. These requirements are not unique to self-funded plans, however the onus to ensure compliance falls more heavily on employers with self-funded plans and can require coordination and negotiation with multiple vendors.

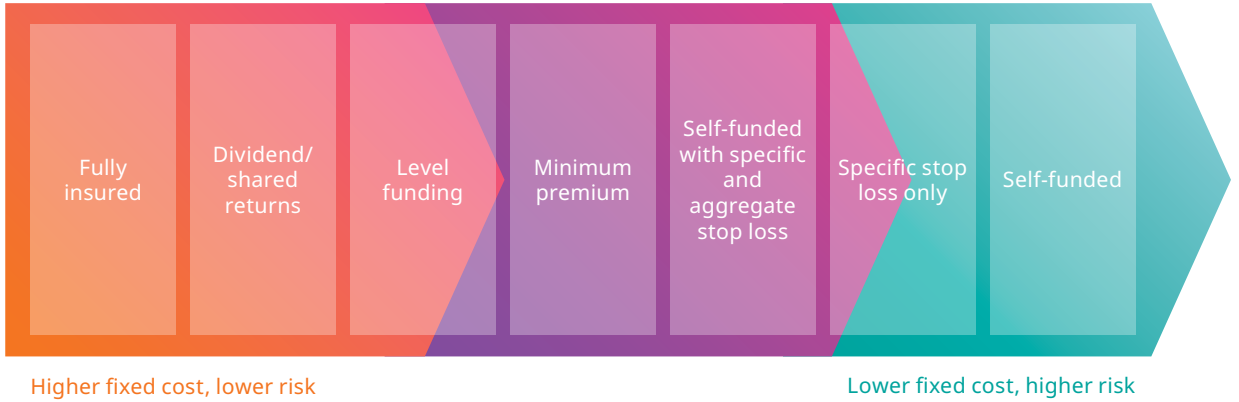
Other compliance requirements

Self-funded employers must also adhere to other federal rules, including complying with Mental Health Parity laws to ensure that mental health benefits are equitable to medical coverage. Upon request, self-funded plans providing medical/surgical benefits and mental health/substance use disorder benefits and imposing non-quantitative treatment limitations (NQTL) must provide comparative analysis of design and application of NQTLs. Additionally, the move to self-funding means Internal Revenue Code (IRC) Section 105(h) self-funded group health plan nondiscrimination testing now applies to the major medical plan. Under the Section 105(h) rules, self-insured health plans cannot discriminate in favor of highly compensated employees with respect to eligibility or benefits.

Other alternative funding arrangements

Not every employer is ready to fully transition to self-funding, and that's okay. Health plan funding operates on a spectrum of risk, meaning employers can ease into alternative funding models that offer some benefits of self-funding without taking on full financial responsibility. Many businesses start with a partially self-funded arrangement, allowing them to gain experience managing claims while maintaining a level of financial predictability. As organizations become more comfortable, they can gradually step up their level of risk exposure and eventually transition to a fully self-funded plan if it aligns with their financial and strategic goals.

Spectrum of risk



Level-funded plans: bridging the gap to self-funding

Level-funding (also known as partially self-funded) is a hybrid approach designed to give smaller and mid-sized employers the advantages of self-funding with the cost stability of a fully insured plan. In a level-funded plan, an employer still self-insures their claims but pays a fixed monthly amount to cover those claims and administrative costs, much like a premium. However, instead of simply handing those funds over to an insurer, the payments are divided into three categories: expected claims, administrative costs, and stop-loss insurance.

The key advantage of level-funding is the potential for a refund at the end of the year if claims are lower than anticipated. If the total amount paid into the plan exceeds what was spent on claims, the employer may receive a surplus refund or apply it toward future costs. This makes level-funded plans an attractive option for smaller employers (such as 25 to 200 employees) that want to test the waters of self-funding while maintaining financial stability. Many employers that transition to self-funding start with level-funding to get accustomed to monitoring claims data and managing cash flow.

Self-funding with and without stop loss

Under a self-funded health plan, the employer pays for all members' claims. Stop-loss insurance can provide financial protection above a certain amount in the event of high-cost claims, such as transplant surgeries or extended hospitalizations. Stop-loss coverage comes in two forms: specific stop-loss, which caps the cost of claims for any single individual, and aggregate stop-loss, which limits total claims liability for the entire group. This protection is especially valuable for mid-sized employers that may not have the financial reserves to absorb high-cost claims. While stop-loss coverage adds an additional cost, it provides a safeguard against extreme financial risk, making self-funding a more predictable and manageable strategy.

Employers that choose to self-fund without stop-loss insurance take on full financial responsibility for claims, which can lead to significant savings but also introduces considerable risk. Large employers with strong cash flow and the ability to absorb high-cost claims are more likely to forgo stop-loss coverage, relying instead on strategic budgeting and data-driven cost management. However, this approach requires a deep understanding of claims trends, plan utilization, and the ability to weather unpredictable spikes in costs. Without stop-loss coverage, employers must be prepared for extreme scenarios, such as specialty drug claims or premature births, that could create significant financial strain.

Reference-based pricing

Employers seeking a more aggressive cost-control strategy may consider reference-based pricing (RBP). Unlike traditional insurance models that negotiate rates through preferred provider networks, RBP sets reimbursement rates based on a reference benchmark, such as Medicare rates or an independent cost database. This approach allows employers to take increased control of pricing rather than being locked into high, potentially unpredictable hospital and provider charges.

With reference-based pricing, an employer typically pays providers a set percentage above Medicare rates rather than the significantly higher rates negotiated by commercial insurance carriers. This can lead to substantial cost savings, often reducing claims expenses by 20% or more. However, because RBP eliminates the need for a traditional provider network, some providers may not accept the plan's payment rates, potentially leading to balance billing issues for employees, where they are charged the difference between what the provider bills and what the insurance pays.

To mitigate these challenges, employers implementing RBP often partner with advocacy firms that negotiate directly with healthcare providers to settle billing disputes. While reference-based pricing may not be the right fit for every organization, it can be an effective way to contain costs and improve pricing transparency for those willing to take a more active role in managing healthcare expenses.

Captive insurance

Captive insurance is an alternative funding approach that allows multiple employers to pool their risks together to achieve cost stability and greater purchasing power. In the context of employee health plans, a group captive allows multiple companies to band together to self-insure their health benefits collectively.

Employers can choose from different captive structures depending on their goals and risk tolerance. Homogeneous captives bring together companies from the same industry or with similar risk profiles, benefiting from specialized claims management and shared industry expertise. Heterogeneous captives pool employers from diverse industries, spreading risk across a broader base, which can help stabilize overall costs. A single-parent captive is owned and controlled by a single employer, offering maximum control over plan design, claims management, and risk financing, but it typically requires significant size and financial resources to establish.

Employers within the captive share in the financial responsibility for claims, but the risk is spread across all members. The captive, in turn, provides stop-loss insurance coverage for all member employers' health plans. In essence, the captive is a reinsurer for the self-funded plans of its members. Each employer still self-funds its own day-to-day claims up to a certain amount, but claims beyond that (either per individual, in aggregate, or both) are covered by the captive pool. Should claims exceed the captive pool threshold, the excess risk layer kicks in and transfers the risk to the external stop-loss insurer, shielding employers from catastrophic losses. This model is especially appealing to midsize employers that may not have the financial reserves to absorb large fluctuations in claims on their own.

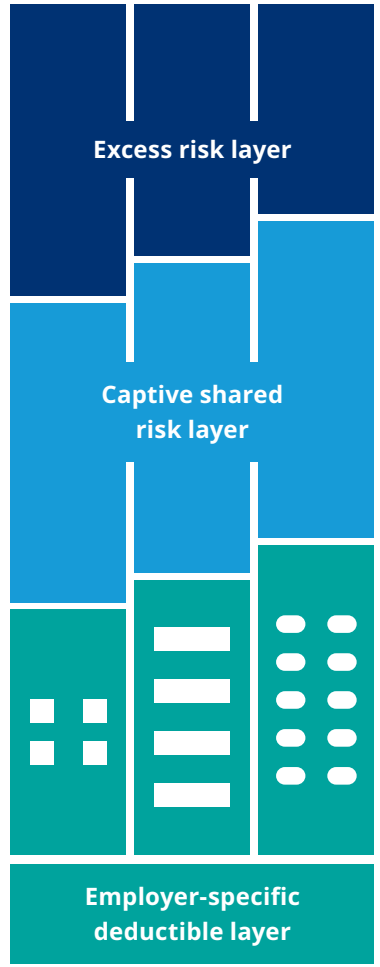
Captive members still get the benefits of self-funding—they can customize their own health plan and get claims transparency—but they also gain bargaining power and economies of scale. Unused premiums or surplus funds in the captive are returned to members in proportion, often annually. This provides a financial incentive: all members are motivated to control claims (through wellness, good plan management, etc.) because lower claims mean everyone shares in the savings. Over a few years, a well-run captive might return significant dividends to members that would otherwise be insurer profits.

Captives do require commitment—typically, there are entry and exit rules, and sometimes initial capitalization. While risk is shared, extremely high-cost events could still impact the group. Despite these complexities, the popularity of group captives for health benefits has grown as health costs rise and mid-market employers seek new solutions.

Finding the right funding strategy for your business

There is no one-size-fits-all approach to funding employee health benefits. Whether an employer is just beginning to explore alternative funding options or is ready to make the leap into full self-funding, there are many paths to greater cost control and flexibility. By working with an experienced benefits advisor, employers can evaluate which approach aligns with their financial risk tolerance, workforce demographics, and long-term business objectives.

For many organizations, the journey to self-funding starts with level-funded plans or captives, allowing them to build confidence in claims management while mitigating downside risk. The key is to find a solution that empowers the employer to take control of healthcare spending while facilitating employees' access to high-quality, cost-effective care.



Key partners in a self-funded program

Self-funding offers employers greater control over their healthcare costs, but that doesn't mean they have to navigate the process alone. Successful self-funded plans rely on a network of partners who help manage risk, handle claims, and optimize plan performance. Understanding the role of each key partner will help employers structure a plan that delivers the best value for their business and employees.

Benefits advisor

A benefits advisor plays a critical role in designing and managing a self-funded plan. Unlike a traditional broker who may focus solely on carrier-based solutions, an experienced benefits advisor provides ongoing strategic support, helping employers:

- Assess whether self-funding is a viable option.
- Structure the plan to align with financial goals and employee needs.
- Identify cost-saving opportunities, such as direct contracting or alternative funding strategies.
- Find the right stop-loss insurance carrier and other key partners.
- Navigate compliance requirements to ensure the plan meets federal and state regulations.
- Continuously analyze claims data to make informed recommendations for plan adjustments.

A trusted benefits advisor acts as an extension of an employer's HR and finance teams, offering expertise to help manage the complexities of self-funding.

Third-party administrator (TPA)

A TPA is responsible for the administrative functions of a self-funded plan, ensuring that claims are processed efficiently and employees receive the support they need. TPAs provide:

- Claims processing and adjudication, ensuring payments are accurate and timely
- Provider network access, offering competitive negotiated rates for medical services
- Plan compliance management, handling reporting requirements for ERISA, HIPAA, ACA, and COBRA
- Member support services, assisting employees with claim questions and benefit utilization

TPAs vary in size and specialization, and employers should choose a partner that aligns with their industry, workforce demographics, and plan goals. Some employers may opt for an administrative services only (ASO) provider, which functions similarly to a TPA but is affiliated with a major insurance carrier. An ASO can also offer familiar processes to plan members, even though the employer is self-funding claims.

Stop-loss provider

One of the primary concerns employers have about self-funding is financial risk. Stop-loss insurance mitigates this risk by reimbursing employers for high-cost claims that exceed a certain threshold. There are two main types of stop-loss coverage:

- **Specific stop-loss:** Protects against large individual claims from high-cost employees or dependents (e.g., a premature birth or a cancer diagnosis).
- **Aggregate stop-loss:** Caps total claim expenses for the entire employee population over a set period, typically a plan year.

A stop-loss provider helps employers determine appropriate deductible levels and risk thresholds based on historical claims data and financial tolerance. Some providers also offer predictive analytics to help forecast potential high-cost claims and recommend proactive management strategies.

Pharmacy benefit manager (PBM)

Prescription drug spending is a major cost driver for employer-sponsored health plans. A PBM helps manage these expenses by:

- Negotiating drug pricing and rebates with pharmaceutical manufacturers.
- Developing formularies (lists of covered medications) to encourage cost-effective prescribing.
- Implementing cost-containment strategies, such as step therapy and prior authorization.
- Providing data insights to track utilization and identify opportunities for savings.

Employers should carefully evaluate PBMs, as pricing transparency and rebate retention policies can vary widely. Some self-funded employers opt for carve-out PBM arrangements, which allow them to contract directly with an independent PBM rather than using one tied to an insurance carrier.

Point solutions and targeted care programs

Self-funded employers often leverage point solutions and targeted care programs to meet specific health needs within their employee populations, including chronic conditions, mental health, wellness, and specialty care (e.g., diabetes management, musculoskeletal conditions, telehealth).

Point solutions offer targeted interventions aimed at enhancing health outcomes and minimizing costs through:

- Specialized support for employees.
- Digital health tools.
- Personalized coaching.
- Convenient virtual care.

Employers also have the option to use carve-out solutions for high-cost or specialized services such as renal care or transplant procedures. By contracting separately for these specific healthcare needs, employers can leverage providers with deep expertise, specialized networks, and negotiated rates, significantly reducing costs and improving the quality of care. Carve-out solutions complement broader self-funded strategies by proactively addressing the most financially volatile and medically complex healthcare episodes.

Taking the next step toward self-funding

Transitioning to a self-funded health plan is an important strategic decision with the potential to significantly impact your organization's healthcare costs, employee satisfaction, and overall financial stability. As you evaluate whether self-funding is the right path for you, consider these key questions:

- **Financial readiness:** Is your organization financially prepared to handle variability in claims and set aside adequate reserves?
- **Risk tolerance:** Are you comfortable taking on more risk for the opportunity to control healthcare costs and retain potential savings?
- **Claims history:** Do you have visibility into your historical claims experience to accurately project future healthcare expenses?
- **Population health:** Do you have a clear understanding of your employee population's health risks, conditions, and healthcare utilization patterns?
- **Administrative resources:** Do you have the internal resources or partners in place to effectively manage compliance, claims administration, and employee communications?
- **Employee engagement:** How will your employees respond to changes in their healthcare plan, and are you prepared to support them through the transition?
- **Data transparency:** Are you ready to leverage detailed claims data to actively manage and optimize your benefits program?

Self-funding can offer substantial rewards in cost savings, plan flexibility, and transparency, but it requires careful planning and expert guidance. Marsh McLennan Agency consultants are equipped to guide employers through this journey, from evaluating funding options to implementing effective strategies tailored to their unique workforce needs. With our experienced consultants, employers can confidently embrace self-funding as a viable solution to manage healthcare expenses while providing quality benefits to their employees.

Ready to explore self-funding?

Contact a Marsh McLennan Agency consultant today to conduct a comprehensive analysis of your current benefits strategy and discover the self-funding opportunities available to you.

MarshMcLennan Agency

About Marsh McLennan Agency

Marsh McLennan Agency (MMA) provides business insurance, employee health & benefits, retirement & wealth, and private client insurance solutions to organizations and individuals seeking limitless possibilities. With 15,000+ colleagues and 300 offices across the United States and Canada, MMA combines the personalized service model of a local consultant with the global resources of the world's leading professional services firm, Marsh McLennan (NYSE: MMC).

Your future is limitless.℠

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MarshMcLennan Agency

Self-funded Readiness Guide

Your future is limitless.℠

If you're reading this, your organization is likely asking an important and strategic question: Is self-funding our medical plan the right move?

As a benefits advisor who has worked with employers across industries, sizes, and growth stages, self-funding is neither a silver bullet nor a reckless gamble. It is a financial and cultural decision that requires clarity, discipline, and readiness.

Over the years, I've seen organizations move from fully insured arrangements to self-funded plans for many reasons: rising premiums, lack of transparency, limited flexibility, or a desire for greater control. In some cases, the transition created meaningful savings and long-term stability. In others, the timing or infrastructure simply wasn't right.

This guide was created to help you determine which side of that equation you may fall on.

As a self-funded plan, instead of paying a carrier a fixed premium and transferring risk entirely, you assume a level of financial responsibility for your employees' claims. This funding model creates greater visibility into your data, plan design flexibility, and potential cost savings when claims are favorable. It also introduces volatility, governance responsibility, and the need for stronger internal processes.

Importantly, readiness is not just about projected savings but I cannot underscore the importance of strong financial modeling. But numbers alone do not determine success.

You must also consider:

- Leadership's tolerance for risk and variability
- Financial stability and cash flow strength
- Organizational discipline around budgeting and forecasting
- Internal resources to manage vendor partners and compliance
- Appetite for transparency and data-driven decision-making

Self-funding is as much an operational shift as it is a financial one.

This readiness guide is designed to help you step back from the sales pitch and think critically. It will walk you through the strategic, financial, cultural, and administrative factors that influence whether self-funding aligns with your organization's goals and capabilities. It is not intended to convince you to self-fund. Instead, it is meant to help you make a thoughtful, informed decision.

Throughout this guide, I encourage you to engage your finance team, executive leadership, and human resources partners.

Self-funding can be a powerful strategy when pursued intentionally and with the right structure in place, but readiness matters.

My hope is that this guide will help you to evaluate not just whether self-funding could work for your organization—but whether it should, and whether now is the right time.

To continue the conversation, I am here to help

Sincerely,

Jamie Hagar

Vice President, Employee Health & Benefits

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Self-funding Your Health Care Plan: A Practical Guide

Assess Organizational Readiness

Self-funding on the surface is simple – it's arithmetic, not emotion. Easy enough, right? While output from a trusted advisor makes the decision appear cut and dry, there are many considerations for employers.

We begin by outlining some of the high-level differences between a self-funded and fully insured health care plans.

Consideration	Self-Funded Plan	Fully Insured Plan
Financial Stability & Risk	Requires strong cash flow and risk tolerance; responsible for paying claims directly	Fixed premiums; insurer assumes risk
Employee Population Size	Best suited for groups of 100+ employees for risk pooling Even groups below 200 or 250 employees should strongly evaluate appropriateness due to claims volatility	Suitable for all sizes, especially smaller groups
Claims Data Availability	Needs detailed historical claims data for accurate forecasting	Less reliance on claims data; insurer manages risk
Stop-Loss Insurance	Essential to limit catastrophic claims risk	Not applicable; insurer covers all claims
Administrative Capabilities	Requires internal expertise or strong TPA/vendor partnerships	Minimal internal admin; insurer handles claims and compliance
Regulatory Compliance	Must comply with federal ERISA rules and other mandates	Insurer manages most compliance elements, however employer is still responsible for knowing what they are responsible for
Plan Design Flexibility	High flexibility to customize benefits and cost-sharing	Limited flexibility; plans are standardized
Cost Considerations	Potential long-term savings; upfront admin and stop-loss costs	Predictable fixed costs; premiums may be higher
Market Trends & Peer Practices	Higher prevalence among larger employers; requires ongoing market monitoring	Common choice for smaller employers; less complex

Estimate HR Team Time Commitment

Task Area	Self-Funded Plan (Hours/Month)	Fully Insured Plan (Hours/Month)	Notes
Vendor Management	8–12	2–4	More vendors to coordinate (TPA, stop-loss, consultants) vs. insurer
Claims Oversight	6–10	1–2	Monitoring claims trends, resolving issues
Compliance & Reporting	6–8	2–3	ERISA reporting, ACA filings, stop-loss compliance
Employee Communication	4-6	4–6	Education on plan design, claims process, and changes
Data Analysis & Strategy	4–6	1–2	Analyzing claims data, cost trends, and plan adjustments
Total Estimated Time	28–42	10–17	Self-funded plans require roughly 2–3 times more HR time

Note: Actual hours vary based on company size, HR team capacity, and vendor support.

Health Plan Funding Decision Framework

Before You Get Started

Your broker partner should provide a detailed financial analysis, including a retrospective and prospective outlook. This should include a review of the financial implications of being self-funded at least two years prior and next year's projection.

Although the details inside this workbook can still help you understand your organization's readiness for self-funding, the financial analysis is paramount.

How to Use This Workbook

1. **Gather your HR, finance, and benefits team** to complete each section collaboratively.
2. **Be honest and realistic** about your organization's capabilities and priorities.
3. **Use the estimated HR time commitments** to assess whether your team can handle the administrative load of self-funding.
4. **Discuss the trade-offs** between financial risk, flexibility, and administrative complexity.
5. **Make an informed decision** based on your organization's unique profile and goals.

Section 1: Organizational Profile

Answer the questions below.

Question	Your Input / Notes
Total number of employees covered	
Current health plan type (Self-Funded / Fully Insured)	
Current budget for health care plan	
Projected budget for health care plan	
HR team size and capacity (number of staff)	
Access to historical claims data (Yes/No)	
What frequency of claims reporting do you currently receive from your broker? Would this change if you were self-funded?	
Current vendor relationships (TPA, broker, etc.)	

Relying on a carrier's self-funded projection ***may*** be enough to help you make a decision, depending on the size of employer. However, it is critical you understand what data they use to formulate your projection. Your broker partner should help you understand what actuarial best practices are used for projecting health care plan spend and demonstrate those in their own unique analysis.

Section 2: Financial & Risk Assessment

Answer the questions below.

Consideration	(Yes/No)	Notes / Comments
1. Does the organization have strong cash flow and risk tolerance?	Unsure	
2. Is the employee population size 100+? *The law of large numbers applies; the larger the group, the risk is spread across more people. Typically, this makes self-funding more suitable for larger organizations.*	Unsure	
3. Is detailed claims data available for forecasting?	Unsure	
4. Are you prepared to purchase stop-loss insurance?	Unsure	
5. Is predictable budgeting a priority?	Unsure	

Your broker should demonstrate extensive experience in forecasting your budget and securing stop-loss insurance.

In addition, you should review a retrospective self-funding analysis as well as a prospective one. This data helps you best understand if the prospective self-funded projection is an anomaly.

Section 3: Administrative & Compliance Capabilities

Answer the questions below.

Task Area	Estimated HR Hours/Month (Self-Funded)	Estimated HR Hours/Month (Fully Insured)	Your HR Team Capacity (Hours/Month)	Notes / Comments
Vendor management	6-10	2–4		
Claims oversight	6–8	1–2		
Compliance & reporting	6–8	2–3		
Employee communication & education	6-10	4–6		
Data analysis & strategy	4–6	1–2		
Total Estimated HR Time	**28–42**	**10–17**		

**Actual hours may vary but, in most cases, you can expect 2-3x the time commitment*

Considerations: Understanding the capabilities of your broker partner is not the focus of this guide but it is critical to evaluating your organization's readiness.

- What role does your broker play in supporting you as a self-funded plan vs. fully-insured?
- Understand compensation differences, if any
- What do they offer in terms of claims oversight, compliance and vendor management?
- What data analysis, procurement solutions, pharmacy management, and network analysis tools do they use?
- Does your broker utilize carrier self-funded plan projections or do they have the actuarial support to develop a budget outside of the insurance carriers?

Section 4: Plan Design & Employee Impact

Consider the questions below.

Consideration	(Yes/No)	Notes / Comments
Is plan design flexibility important?	Unsure	
Are you prepared to educate employees on plan mechanics?	Unsure	
Do you want to customize wellness or cost-sharing programs?	Unsure	
Is employee satisfaction a top priority?	Unsure	

Once you become a self-funded plan, employee wellbeing is no longer just a cultural initiative—it is a financial strategy.

Under a fully insured model, poor health trends show up as higher renewal premiums. Under a self-funded arrangement, they show up directly on your balance sheet. Every unmanaged chronic condition, delayed preventive visit, untreated behavioral health issue, or avoidable emergency room claim becomes a cost your organization funds in real time.

That shift changes the role of wellbeing entirely.

Wellbeing initiatives—when thoughtfully designed and aligned with your population's needs—help manage risk, stabilize claims volatility, and improve long-term cost predictability. Programs that support preventive care, chronic condition management, mental health access, musculoskeletal health, and healthy lifestyle engagement are not "nice to have." They are core components of a sound risk management strategy.

Considerations:

- Understand what educational support you'll receive from your broker partner.
- How will they infuse wellness into your plan offerings?

Section 5: Cost & Market Considerations

Consider the questions below.

Consideration	(Yes/No)	Notes / Comments
Are you willing to invest in upfront administrative and stop-loss costs?	Unsure	
Is long-term cost savings a key goal?	Unsure	
Have you benchmarked against industry peers?	Unsure	
Are you prepared to monitor regulatory changes?	Unsure	

Considerations:

- What benchmarking detail do you receive?
- How will your broker keep you up to date on regulatory changes that impact you?

Section 6: Final Assessment & Decision

Final Considerations:

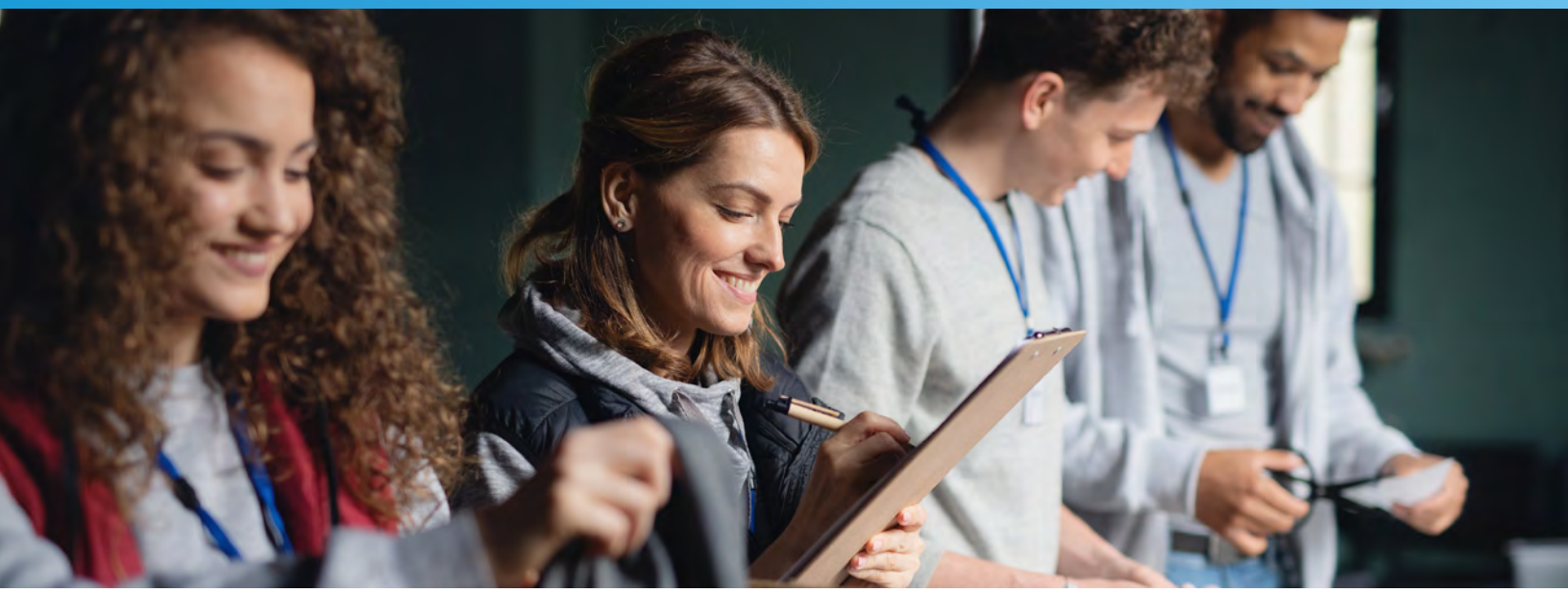
- Based on the above, which plan type aligns best with your organization's needs?
- What are the top 3 factors influencing your decision?
- What additional resources or support do you need to proceed?
- Estimated timeline for implementation
- Do you have the right broker partner? Contact Lauren Fabbri to learn more about our Broker Evaluation Tool.

Next Steps

Congratulations! You completed the Self-funding Readiness Guide. Whether you decide to self-fund your medical plan this year, or not, you've now engaged the right parties within your organization and conducted a thorough readiness assessment to review with the financial results.

Here's the thing with being self-funded, it's easy to "get in," but it's a little more challenging to "get out." When you become self-funded, there is a lag time for claims processing, so the first few months your spend is light and the future is bright! Should the plan perform worse than anticipated, and you desire to be fully insured again, you'll have a number of months where you will pay the run-out claims and the fully-insured premium, which puts pressure on cash flow. You should have full confidence in the analysis provided to you and your broker's ability to support you once you are self-funded.

If you need help, Marsh McLennan Agency is here for you.



Employee health and benefits for human service and non-profit

Tailored solutions with a human touch.

Your organization offers time and care to help those in your community. However, providing support starts from within. Companies can support their current workers and appeal to potential ones by offering benefits that focus on workers' health and well-being. Marsh McLennan Agency's expansive data and knowledgeable specialists can help you craft a benefits program that nurtures your workforce, letting them focus on their mission.

Core solutions

- Actuarial services
- Captive solutions
- Compliance support and oversight
- Dimensions of well-being consulting
- Employee communications support
- Global benefits management
- Rx Solutions
- Strategic plan management
- Technology solutions
- Virtual and mobile benefits solutions
- Voluntary benefits
- Workers' Health 360

A partnership that helps those inside and outside of your organization.

Let's create a benefits strategy that makes "care" more than just a word.

Where partnerships become personal:
Ensure your employees feel valued with wellness programs and strategies that fill the gaps in your employee health and benefits plan. Our industry specialists act as an extension of your team, bringing knowledge and personal care to your mission.

Numbers and data that help you give back:
Turn your data insights into impactful benefits for your employees. Data and benchmarking can help you dig deeper into your employees' well-being. These insights, paired with our solutions and services, can help with your benefits transitions and wellness challenges.

Solutions that enhance your community:
Your community deserves care that fits its needs. So do your employees. We go beyond the usual insurance perks to help you care for your community. From employee health and benefits that care for your workers to the insights found with Workers' Health 360, create a benefits package fit for your organization.

Help for the helping hands:
Whether you're a food bank or an after-school program, giving back to your community starts with the care you provide within your organization. Our knowledge of the trends and innovations in your industry will help you care for your employees now and into the future.

Give a little more support to your employees with tailored and well-executed plans for their well-being.

- **Employer of choice**
- **Increased employee engagement**
- **Fewer injuries**
- **Lower absenteeism**
- **Higher employee productivity**
- **Lower claims cost**

Ready to get started? Reach out to a consultant today and see how Marsh McLennan Agency can help your organization.

Business Insurance
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