

ISSUE BRIEF

Self-Funded Employer Plans

From Premiums to Performance: Managing Risk in Self-Funded Health Plans

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INTRODUCTION

In our first brief, *Employer-Sponsored Health Benefits: Considering Self-Funding*,¹ we outlined the fundamentals of self-funding. In this paper, we outline the practical steps toward establishing and managing a successful self-funded health plan.

Early decisions include selecting third-party administrators and other vendors, defining benefit designs, and implementing cost-saving strategies, including stop-loss insurance and effective care management programs. One of the most critical early decisions is how to fund the plan. Transitioning from a fully insured arrangement to a self-funded plan requires thoughtful planning to ensure ongoing costs are covered and adequate surplus is maintained for unexpected claims.

Simply matching prior fully insured premiums rarely reflects the true cost structure of a self-funded plan. Claims volatility introduces both risk and opportunity. Favorable experience can generate surplus and long-term savings, whereas adverse experience can create short-term funding pressure. Establishing an appropriate funding margin and surplus policy helps stabilize results and ensure the plan's financial sustainability across multiple years.

FUNDING AND REVENUE SOURCES

In a fully insured arrangement, premiums are paid to the health insurance carrier and typically funded through employer and employee contributions. Once self-funded, employers gain greater transparency into expenses and increased control over how the plan is financed. A clear funding strategy should identify all potential revenue sources and how they will be managed to ensure ongoing plan solvency and stability.

*Replicating prior fully insured premium levels rarely captures
the true cost of operating a self-funded plan.
A deliberate funding strategy is critical to maintaining long-term stability.*

¹ Pool A, Walker J, Garrity T. *Employer-Sponsored Health Benefits: Considering Self-Funding*. Wakely Issue Brief. September 2025. Available at: https://www.wakely.com/wp-content/uploads/2025/09/Wakely-White-Paper-Self-Funding_2025.09.25.pdf.

Employer and Employee Contributions

If the employer previously paid 100% of the fully insured premium, the funding structure under self-funding may seem familiar, but the underlying risks differ. Rather than simply replicating past premium levels, projections must reflect expected claims volatility and administrative costs. In addition, employers should be mindful that an increase in large claims relative to prior years could result in insufficient funding projections that will require supplemental contributions to sustain the plan. Conversely, favorable claim experience can generate savings and establish a cushion for future volatility.

If the employer-sponsored plan has been sharing the premium responsibility between the employer and employee, the contribution structure will likely remain similar. Changes in the total revenue needed to support the plan may reflect changes in benefit design, projected expenses, or the need to build early-stage surplus. Contribution strategy can also influence enrollment behavior and plan selection. Employers should consider how employee contributions by plan and coverage tier could affect migration, adverse selection, and the overall cost profile of the self-funded plan.

Employers should periodically review contribution levels to ensure sufficient total funding. Two common strategies include:

- **Establishing a surplus reserve:** Allocating a portion of funding to a dedicated reserve account helps smooth volatility from high-cost claims or timing mismatches between cash inflows and claim payments.
- **Leveraging general operating funds when necessary:** This approach provides flexibility to absorb short-term claim spikes, but should be supported by clear internal accounting and governance.

Prescription Drug Rebates

Under fully insured plans, carriers may apply prescription drug rebates to offset premium increases; however, employers are unlikely to receive a direct accounting of the rebates or how those funds are credited.

In a self-funded arrangement, rebates are typically paid directly to the employer on a quarterly basis by the pharmacy benefit manager (PBM), who negotiates rebates with drug manufacturers. Employers rarely see underlying rebate details, such as which drugs are eligible or their associated utilization; however, the contractual agreement between the employer and PBM should include explicit language regarding rebate estimates and guarantees.

While prescription drug rebates provide a periodic cash inflow, they should not be viewed as a stand-alone revenue source. In a sound actuarial funding approach, expected rebates are incorporated into projected plan costs and inherently reflect employer and employee contribution levels.

Employers should ensure their PBM contract specifies the following information:

- The methodology for rebate pass-through, any spread pricing arrangements, point-of-sale rebate treatment, and timing of payments
- Whether rebate guarantees apply at an aggregate or per-claim level
- The level of reporting available to verify performance

Rebate payments can still serve an operational role in smoothing cash flow or replenishing reserves during favorable experience periods, but they should be viewed as a planned component of total funding rather than as a separate revenue stream.

Interest or Investment Income

In fully insured plans, any interest or float on premiums may or may not be credited to the employer. In the self-insured environment, interest or investment income may accrue to provide additional revenue. Surplus funds may be invested in various financial vehicles² to allow for investment income on plan reserves, which can further strengthen financial stability.

Additional Financial Considerations

Some employers also generate modest inflows beyond traditional funding sources. Examples include:

- **Wellness incentives or carrier reimbursements:** Payments tied to wellness program participation, biometric screenings, or health initiative outcomes.
- **Subrogation recoveries:** Recoveries from third parties responsible for medical costs (e.g., auto or liability claims).
- **Vendor performance guarantees or administrative credits:** Refunds or incentive payments tied to TPA, PBM, or care management performance.
- **Stop-loss reimbursements:** These payments can be significant and are intended to reimburse the plan for claims already paid above the stop-loss deductible. They are not

² Different jurisdictions may require a certain amount of surplus be maintained in liquid accounts to ensure the availability for paying claims. Employers should check with their state to confirm regulations.

new revenue, but rather recovery funds that offset prior expenses and must be tracked and reconciled carefully to reflect true net plan costs.

- **Reinsurance or captive dividends (if applicable):** For employers participating in group captives or trust arrangements, favorable experience may generate surplus distributions.

The magnitude and frequency of these inflows may vary, but each plays a role in the plan's financial position and should be incorporated into accounting and reporting processes. Proper classification of stop-loss recoveries and other reimbursements helps maintain transparency and accuracy in evaluating net plan performance over time.

MANAGING RISK AND CONTAINING COSTS

Although effective funding provides financial stability, managing the variability of healthcare costs is equally important. Both employers and employees benefit when plan costs are predictable and well managed. Because claim costs can fluctuate widely, especially for smaller groups, self-funded plans rely on targeted tools to manage volatility and support long-term sustainability. Two of the most important components are stop-loss insurance and care management.

A well-designed self-funded plan balances financial protection, proactive management, and flexibility to adapt as costs evolve.

Stop-Loss Insurance

Stop-loss insurance provides financial protection against catastrophic or unpredictable claims and supports the stability of plan funding. Stop-loss insurance has two components:

- Specific stop-loss reimburses the plan for each member's costs (or a portion of the costs) above a defined deductible.
- Aggregate stop-loss reimburses the plan when total claims, net of specific stop-loss recoveries, exceed a predetermined threshold (typically 20–25% above expected claims).

Specific and aggregate stop-loss protection may be purchased separately but are often more cost-effective when integrated in a single contract. Attachment points should reflect the employer's financial capacity, cash flow tolerance, and appetite for risk. Employers should also evaluate key contract provisions such as lasers, run-in and run-out coverage, aggregation of

specific deductibles, and reimbursement timing, as these terms can materially affect the level of protection provided.

Care Management

Care management is another essential mechanism for controlling costs and improving health outcomes, particularly for high-cost or complex conditions. Effective programs combine member outreach, clinical coordination, and provider engagement to influence care decisions and prevent avoidable costs.

Care management activities typically include:

- Avoiding unnecessary or inefficient utilization of services
- Helping members manage chronic conditions through proactive case management
- Identifying emerging risks through claims analytics, predictive modeling, or clinical referrals
- Collaborating with providers to coordinate appropriate care
- Guiding members toward high-value, cost-effective providers

When implemented effectively, care management reduces cost volatility, supports a healthier workforce, and improves overall plan value.

Other Strategies to Manage Cost and Risk

Employers have several other tools to help manage cost and risk. Each can play a role in improving plan performance when used in coordination with robust analytics and sound governance. Key areas of focus include:

- **Plan design optimization:** Structuring benefits to encourage preventive care, promote appropriate utilization, and support high-value provider choices, while monitoring how benefit and contribution changes may influence enrollment behavior, affordability, and adverse selection.
- **Actuarial monitoring and benchmarking:** Ongoing analysis of claim trends, funding adequacy, emerging risk, and large-claim exposure ensures that contributions and reserves remain aligned with historical and projected experience.
- **Pharmacy benefit management:** Active oversight of PBM contracts, formulary management, specialty drug programs, biosimilar adoption, and site-of-care strategies helps manage one of the fastest-growing components of plan costs.
- **Vendor integration:** Collaboration among TPAs, PBMs, care management partners, and wellness vendors eliminates data silos and improves member outcomes.

- **Network and steerage strategies:** High-value network designs, tiered networks, centers of excellence, reference-based pricing, or direct provider contracting can reduce cost variation and improve quality.
- **Broker and actuarial partnership:** Engaging experienced advisors ensures that decisions are grounded in data, compliance, and market intelligence.

These strategies work best when coordinated under a consistent governance and analytic framework that monitors outcomes, identifies emerging risks, and continuously refines the self-funded program.

ALTERNATIVE FUNDING OPTIONS

Employers have several ways to balance predictability and flexibility when structuring self-funded programs. While traditional self-funding involves direct payment of claims as they occur, many hybrid or pooled arrangements provide a smoother financial experience or allow smaller employers to participate in self-funded models.

Level Funding

Level funding combines elements of fully insured and self-funded arrangements. As the name suggests, employers pay a fixed monthly amount that covers expected claims, administrative costs, and stop-loss premiums. Because of the fixed monthly payment, this arrangement feels similar to fully insured plans. Most level funding arrangements contain a refund component if claims are lower than expected, while others also include downside risk if claims exceed a defined threshold.

Level funding plans are attractive to smaller plans (fewer than 200 employees) and can be a first step toward self-funding without the full impact of claim fluctuation. Employers should review contract terms carefully to understand how settlements are calculated, the portion of unspent funds that are returned, and whether stop-loss protection applies on a group or pooled basis.

Health Reimbursement Arrangement

A health reimbursement arrangement (HRA) allows the employer to save on costs by offering a higher-deductible plan while funding employee accounts to reimburse qualified medical expenses. The funds are not portable and may not be used for non-necessary costs, but they allow the employer to share cost responsibility while maintaining affordability for employees. Key features include:

- Funds from the HRA are tax-free to the employee and tax-deductible for employers.
- Rules for unused HRA funds (loss or rollover parameters) are defined by the employer.

The flexibility of an HRA helps employers manage costs while giving employees meaningful financial protection when care is needed. Employers should model potential claim shifts carefully to ensure the combined plan and HRA structure meets both cost and utilization goals.

Captive Insurance

A captive arrangement can take many forms—from a single-parent captive to a group captive that allows multiple employers to share risk. Captives are licensed and regulated entities that function much like insurance companies but are owned by their member organizations.

Surplus remains within the captive and may be shared among participants based on their experience. Captives offer greater control and transparency than traditional insurance, but they also require upfront capital, specialized management, and ongoing regulatory oversight. Employers participating in a group captive should understand how losses and surplus are allocated and how governance decisions are made among members.

Trust Funding

Trusts are similar to captive insurance arrangements in that they bring together a group of like entities, but trusts are legal or financial arrangements—not licensed entities. Associations, industry groups, or other coalitions of employers often use them to achieve collective purchasing power and administrative efficiency.

Trust members gain collective buying power for services such as administrative, stop-loss, and other expenses that self-funded plans typically outsource. The trust itself is not established to pay claims, but may hold funds to support claim payment. Fund and asset management are the primary duties of the trust, along with other responsibilities defined when the trust is initiated. Members are liable for their own funding obligations and are not directly affected by the performance of other members.

CONCLUSION

The transition from a fully insured to a self-funded health plan requires thoughtful evaluation of funding sources, cost-control mechanisms, and overall risk tolerance. Employers can build long-term stability by aligning contribution strategies, reserves, and investment policies with projected costs and plan objectives.

Ongoing actuarial monitoring and strategic vendor coordination turn self-funding from a financial mechanism into a managed business strategy.

A sustainable self-funded program also depends on ongoing oversight and proactive management. Tools such as stop-loss protection, care management, and strategic partnerships with actuaries, brokers, and administrative vendors help employers navigate claim volatility and maintain predictable results.

With careful planning and disciplined financial management, self-funding can offer employers both flexibility and transparency, creating an opportunity to control costs, tailor benefits, and reinvest savings to support employee health and organizational goals.

Achieving these results requires skilled professionals who understand both the financial and operational dynamics of self-funding. Actuaries, brokers, and administrative partners provide data-driven insights and strategic guidance for employers to manage costs effectively and adapt to changing market conditions.

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