Model Optimal Care
AI-Powered Health Plan Consulting

WHITE PAPER

Becoming Self-Funded

A strategic framework for employers weighing the move from fully insured to self-funded health coverage

> Sixty-seven percent of covered U.S. workers are already in self-funded plans. This paper sets out what the structure is actually worth, what it costs to get there, what risk you take on, and what the 2026 fiduciary rules now require of you.

Jude Odu
Author, *Model Optimal Care: End U.S. Healthcare Waste, One Health Plan at a Time*

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MODEL YOUR OWN NUMBERS

Every figure in this paper is a benchmark, not a forecast for your plan. An interactive cost model accompanies this white paper at **analyze.health**. Enter your plan size, industry, and current premium to see what the structure is worth against your own population.

A NOTE ON WHAT CHANGED IN THIS EDITION

This second edition refreshes every figure to the most recent published source available in August 2026, rebuilds the financial model on a component basis so each input can be checked independently, and adds the 2026 regulatory and litigation developments that now shape the fiduciary case for self-funding. A full change log appears in the back matter, under About this analysis.

OVERVIEW

Executive summary

Self-funding is no longer the exception. Sixty-seven percent of covered U.S. workers are enrolled in a self-funded plan, including 80 percent at firms with 200 or more workers.[1,2] For most employers of scale, the question is no longer whether to self-fund. It is whether you are running a self-funded plan well.

This paper is written for the CFO, HR leader, or benefits advisor who has to make or defend that decision. It does three things. It quantifies what the funding structure itself is worth, separated from what your vendors and your data can deliver on top of it. It sets out the risk you take on, in cash flow terms. And it maps the fiduciary obligations that arrived in 2026 and that now apply to you whether or not you self-fund.

KEY FINDINGS

67%
of covered U.S. workers are now in self-funded plans

2% to 5%
structural savings from the funding change alone, before any contract work

9.9%
highest published 2027 medical trend, steepest in about 15 years

4 to 8
months to recover implementation cost in every modeled scenario

What we found

The structural savings are real, and narrower than the market headline. Self-funding removes the insurer's risk margin, the state premium tax, and the carrier's retained administrative load. It replaces them with a stop-loss premium, a third-party administrator fee, and network access charges. Netting one against the other on published medical loss ratio data leaves a structural advantage of roughly 3 percentage points of total plan cost, with a defensible range of 2 to 5 percent. For a 1,000-employee organization at current market rates, that is about $370,000 to $830,000 a year. It is a good return. It is not the 20 to 40 percent that vendor marketing promises.

The bigger prize is the data, and it is conditional. Self-funding gives you your own claims file. That is the precondition for payment integrity auditing, pharmacy contract renegotiation, site-of-care steerage, and high-cost claimant management. None of that happens automatically. Employers who self-fund and then do nothing with the data capture the structural savings and stop there.

You take on cash flow variance, not just cost. A fully insured premium is twelve identical payments. A self-funded plan is twelve different ones, and a single catastrophic claimant can move a month by 60 percent or more. Stop-loss caps the annual exposure. It does not smooth the month. Plans that fail here fail on liquidity, not on arithmetic.

The fiduciary bar moved in 2026. The Consolidated Appropriations Act of 2026, signed on February 3, extended direct and indirect compensation disclosure to nearly every group health plan service provider.[23] In March, *Stern v. JPMorgan Chase* became the first of the major health plan fee cases to survive a motion to dismiss in part, sending prohibited transaction claims into discovery.[25] Self-funding does not create this exposure. It gives you the data to answer it.

What we recommend

Run the feasibility analysis on 24 to 36 months of your own claims before you model a single savings figure. Budget $90,000 to $235,000 for implementation and expect to recover it inside the first plan year. Treat the third-party administrator selection as the decision that determines everything downstream. Fund a reserve equal to one to two months of expected claims before go-live, not after. And write your fee disclosure and vendor audit rights into the contract on day one, because retrofitting them is far harder than negotiating them.

The detail sits in the sections that follow. Section 3 carries the financial model. Section 4 carries the regulatory calendar. Section 7 is a readiness assessment you can complete in twenty minutes with your broker.

SECTION 1

Why the funding question is back on the table

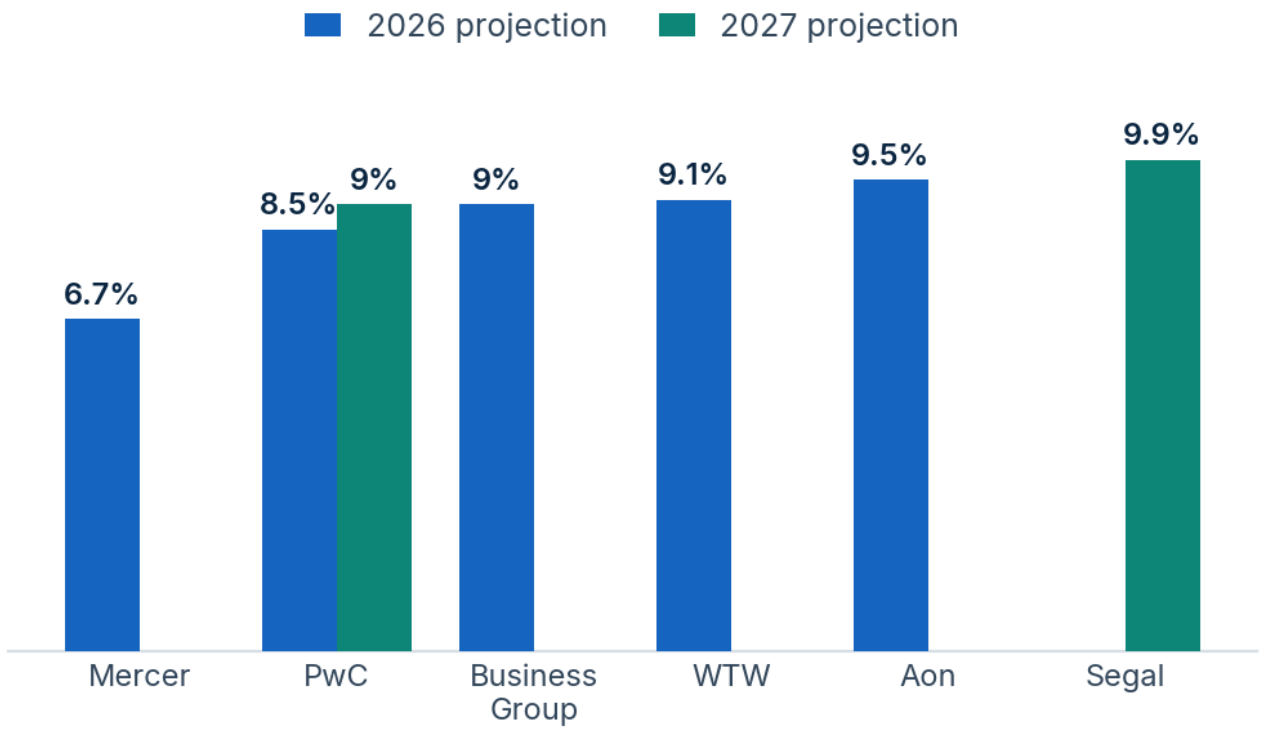
Employers have absorbed a decade of health cost increases by shifting the difference onto employees. That path is closing. The 2027 projections are the steepest in roughly fifteen years, and the deductible lever is largely spent.

The trend line is accelerating, not flattening

Every major benefits consultancy publishes an annual cost trend projection. For 2026 they clustered between 6.7 and 9.5 percent.[6,9,10,11,12] For 2027, the first two published figures are higher still. PwC put group market trend at 9 percent and called it the highest in seventeen years. Segal put medical trend for open access PPO and POS plans at 9.9 percent, with prescription drug trend at 11.5 percent.[8,13]

EXHIBIT 1

Projected employer health cost trend has moved up in every published forecast for 2027



Sources: Mercer, November 18, 2025; PwC Health Research Institute, Behind the Numbers 2026 and 2027; Business Group on Health, August 19, 2025; WTW, September 22, 2025; Aon, September 10, 2025; Segal 2027 Health Plan Cost Trend Survey, July 23, 2026.
Note: Figures are not directly comparable. Some are stated before plan design changes and some after. Mercer reports cost per employee after employer actions; Aon and WTW report before. Aon, WTW, Mercer, and Business Group on Health had not published 2027 projections as of August 19, 2026.

The spread between these numbers is itself informative. Mercer's 6.7 percent for 2026 reflects cost per employee after employers took action. Aon's 9.5 percent reflects what

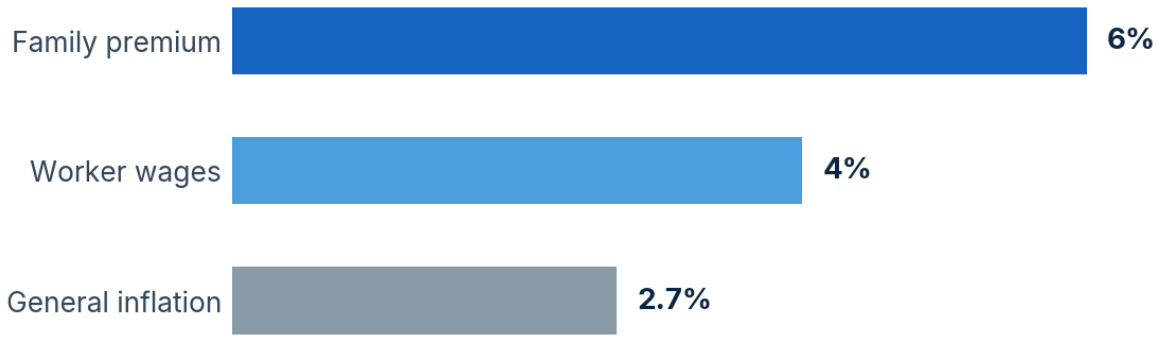
happens if you take none. The gap of nearly 3 points is the value of active plan management, and capturing it requires seeing your own claims.

Cost shifting has reached its limit

The traditional response to a hard renewal has been to raise the deductible and move more of the premium onto the employee. In 2025 the average family premium reached $26,993 and the average single premium reached $9,325. Workers contributed $6,850 toward family coverage out of their own paychecks.[4] Mercer reported in June 2026 that employers are shifting a further share of cost onto employees.[7] The family premium rose 6 percent that year, against wage growth of 4 percent and general inflation of 2.7 percent.

EXHIBIT 2

Family premium growth outpaced both wages and inflation in 2025



Source: KFF, 2025 Employer Health Benefits Survey, October 22, 2025. Survey of more than 1,800 employers with at least 10 workers.

When premium growth runs at one and a half times wage growth year after year, the arithmetic ends somewhere. Employees notice, recruiting suffers, and the deductible increase that closed last year's gap creates this year's access problem. The pressure has moved from the employee side of the ledger back to the plan side, which is where the funding structure lives.

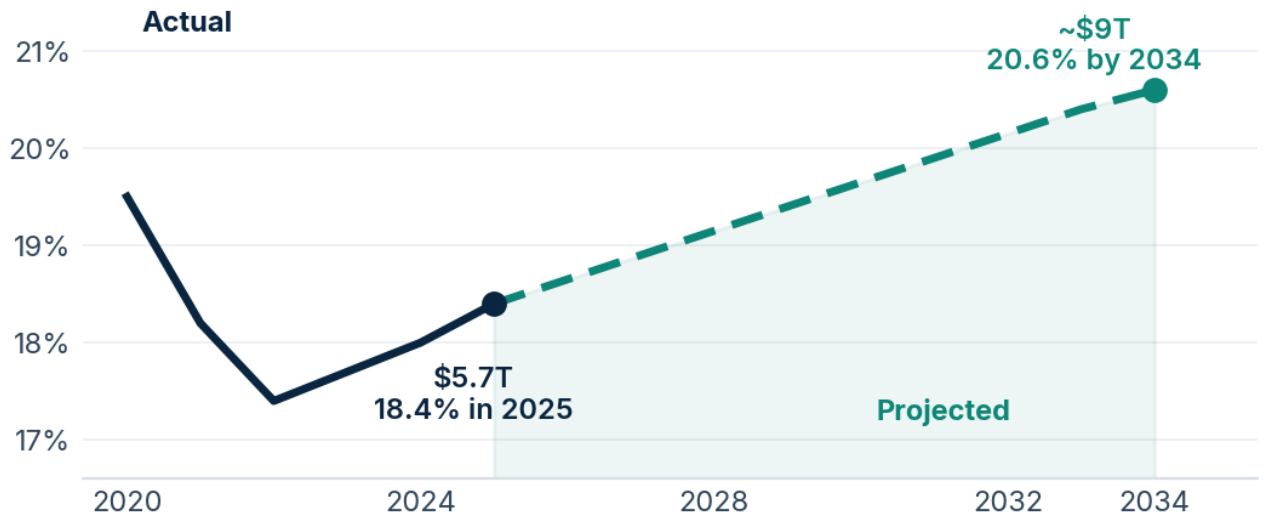
> *The funding structure does not lower the price of an MRI. It determines whether you can see what you paid for it.*

The macro picture supports the same conclusion

National health expenditures reached $5.7 trillion in 2025, a rise of 7.3 percent in a single year and the third consecutive year of growth above 7 percent. Health care now claims 18.4 percent of gross domestic product. The CMS Office of the Actuary projects spending will approach $9 trillion by 2034, at 20.6 percent of GDP, growing at an average 5.4 percent a year against GDP growth of 4.1 percent.[3,5]

EXHIBIT 3

Health spending is projected to claim 20.6 percent of GDP by 2034



Sources: CMS Office of the Actuary, National Health Expenditure Projections 2025 to 2034, released June 24, 2026; Health Affairs, National Health Expenditure Projections 2025 to 34.
Note: The 2020 spike reflects a contraction in GDP during the pandemic rather than a jump in spending. Projected values are interpolated between published waypoints.

Where the money is going

Three drivers account for most of the pressure, and each one behaves differently under a self-funded structure.

Driver	Current picture	What self-funding changes
Specialty pharmacy	Specialty drugs represented 52 percent of total net pharmacy spend in 2024, driven by under 2 percent of utilization. Specialty trend ran 11.1 percent in 2025.[17,18,19]	You contract the pharmacy benefit manager directly and can require pass-through pricing, rebate transparency, and an audit right.
Hospital and facility	The largest cost category in nearly every commercial plan, with wide price variation for identical services inside the same market.	Network selection becomes a decision rather than a package. Direct contracting, reference-based pricing, and centers of excellence all become available.
High-cost claimants	A small number of members drives a large share of spend in any given year, and the composition changes annually.	You see them in your own data, in near real time, rather than in a carrier summary the following year.
Administrative load	Insurers must spend at least 85 percent of large group premium on claims and quality. The 2024 fully insured group market loss ratio was 88 percent.[14,15]	The residual 12 percent becomes negotiable, component by component, instead of embedded in a single premium.

Table 1. Primary cost drivers and the effect of funding structure. **Sources:** Navitus Drug Trend Report 2026; Evernorth; KFF Medical Loss Ratio explainer; KFF Health Insurer Financial Performance in 2024.

SECTION TAKEAWAYS

1. **The trend is accelerating.** Published 2027 projections run 9 to 9.9 percent, the steepest in roughly fifteen years.
2. **Cost shifting is close to spent.** Family premiums rose 6 percent in 2025 against 4 percent wage growth. The deductible increase that closed last year's gap creates this year's access problem.
3. **Structure changes visibility, not unit price.** The decision in front of you is about what you can see and act on, which is why the data matters more than the savings percentage.

SECTION 2

How self-funding actually works

In a fully insured plan you buy a promise. In a self-funded plan you buy services and keep the risk. Everything else follows from that one distinction.

Under a fully insured arrangement, you pay a fixed premium and the carrier pays the claims. If claims run high, the carrier absorbs it. If claims run low, the carrier keeps the difference. Under a self-funded arrangement, you pay claims as they are incurred, you buy administrative services from a third-party administrator, and you purchase stop-loss insurance to cap the downside. Good years accrue to you. Bad years do too.

Feature	Self-funded	Fully insured
Who holds the risk	The employer, with stop-loss above the attachment point	The insurance carrier
Plan design	Set by the employer within federal limits	Chosen from the carrier's filed products
Claims data	Full detail, typically monthly	Summary reporting, often limited by group size
Primary regulator	Federal. ERISA, ACA, COBRA, HIPAA, CAA	State insurance law plus federal minimums
Cash flow	Variable. Claims paid as incurred	Fixed. Twelve equal premium payments
State premium tax	Not applicable	Applicable. Generally up to about 2 percent for health lines[16]
State benefit mandates	Generally preempted by ERISA	Applicable
Surplus in a good year	Retained by the plan	Retained by the carrier

Table 2. Structural comparison of funding arrangements. **Note:** ERISA preemption of state benefit mandates is broad but not absolute. Confirm the position in each state where you have members with ERISA counsel.

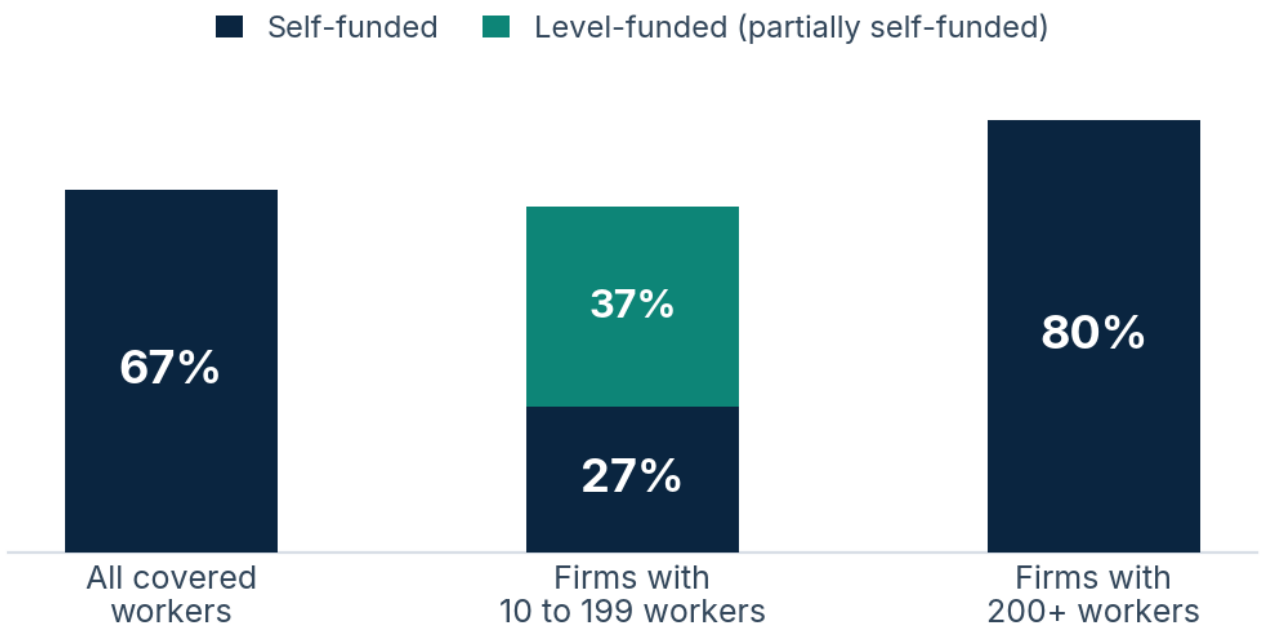
Level-funded plans are a different thing

The market often folds level-funded arrangements into the self-funded category. They are not the same. In a level-funded plan you pay a fixed monthly amount, the carrier administers a small self-funded component with stop-loss attached, and any surplus is settled at year end. KFF reports that 37 percent of covered workers at firms with 10 to 199 workers are in level-funded plans, alongside 27 percent in fully self-funded plans.[1] Enrollment in self-funded arrangements has trended upward across firm sizes for a decade.[20]

Level funding is a reasonable entry point for a smaller employer. It gives you some claims visibility and some upside participation without the cash flow variance. It does not give you the full data file, the contracting freedom, or the ability to change administrators without changing everything else. Read any adoption statistic carefully to see which definition it uses.

EXHIBIT 4

Self-funding is near universal among larger employers and now reaches most of the small group market through level funding



Source: KFF, 2025 Employer Health Benefits Survey, October 22, 2025.
Note: KFF limited the 2025 survey to firms with 10 or more workers, where prior years included firms with 3 or more. KFF cautions that this breaks year over year comparability, so part of the increase from 63 percent in 2024 to 67 percent in 2025 reflects the sample change rather than employer behavior.

The parties you take on

A fully insured plan has one counterparty. A self-funded plan has four or five, and each one is a separate negotiation with separate economics.

- **Third-party administrator or ASO provider.** Adjudicates and pays claims, runs member services, produces your reporting. This is the decision that constrains everything downstream, because it determines what data you get and in what form.

- **Network.** Often rented from a national carrier, sometimes assembled directly, sometimes replaced with reference-based pricing. Priced per employee per month on top of the administrative fee.
- **Stop-loss carrier.** Sells you the catastrophic protection. Underwrites annually, which means your renewal reprices against your own experience.
- **Pharmacy benefit manager.** Frequently the largest single lever available to a self-funded plan, and the one where contract language matters most.
- **Consultant or broker.** Advises on the above. Under CAA 2021 and now CAA 2026, must disclose direct and indirect compensation to you in writing.[23]

WHAT THIS MEANS FOR A 500-LIFE EMPLOYER

At 500 covered employees you are large enough for full self-funding to work and small enough that a single catastrophic claimant materially moves your year. Buy a lower specific stop-loss deductible than a 2,000-life employer would, expect to pay more for it as a percentage of spend, and put the aggregate contract in place rather than treating it as optional. The structural savings are still there. The variance is simply less forgiving.

What self-funding removes, precisely

The carrier's retained share of a fully insured premium covers administration, broker compensation, state premium taxes, risk margin, and profit. The Affordable Care Act caps that share at 15 percent in the large group market and 20 percent in the small group and individual markets. Actual 2024 experience in the fully insured group market ran at an 88 percent loss ratio, leaving roughly 12 percent for everything else.[14,15]

Self-funded plans are not insurers and are not subject to the medical loss ratio rule. But they do not eliminate that 12 percent. They unbundle it. You still pay for administration. You still pay for network access. You still pay a risk charge, now in the form of a stop-loss premium. What you stop paying is the insurer's margin on your claims dollars and the state premium tax on the whole premium. Section 3 puts numbers on the difference.

SECTION TAKEAWAYS

1. **You trade one counterparty for four or five.** Administrator, network, stop-loss carrier, pharmacy benefit manager, and advisor are separate negotiations with separate economics.
2. **Level-funded is not self-funded.** Check which definition any adoption statistic uses before you cite it.
3. **You unbundle the retention layer, you do not remove it.** What disappears is the insurer's risk margin and the state premium tax, not the full 12 percent.

SECTION 3

What the structure is worth

A single average savings figure cannot carry much weight here, because the employers who self-fund are not the same as the ones who do not. What can be modeled cleanly is the retention layer: what a carrier keeps, against what your vendors will charge you instead.

HOW THIS EDITION MODELS SAVINGS

The first edition expressed the opportunity as a single headline figure, $2,760 per employee per year, together with a first-year reduction range of 20 to 40 percent. Those came out of the cost model behind **analyze.health**, built on industry benchmarks gathered for that project, and they remain a reasonable read of what the tool produces when you feed it a plan with meaningful recoverable waste.

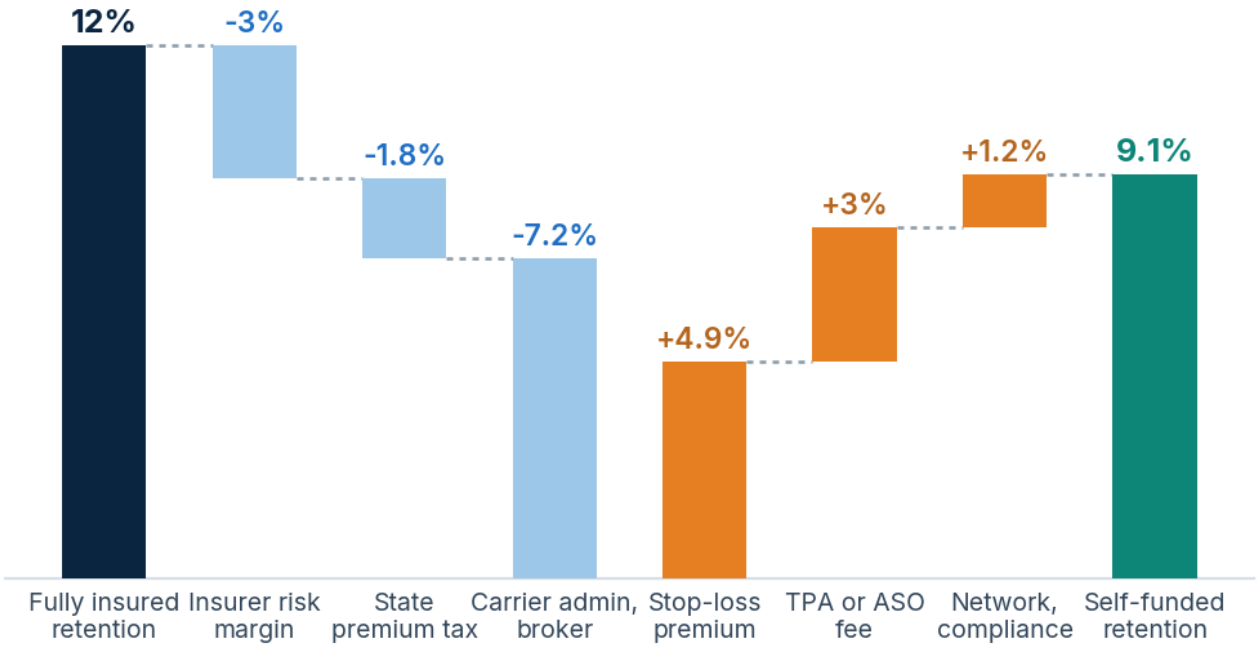
This edition takes a different approach, for a reason worth stating. A single average is hard for a reader to audit, and it invites a comparison that the data cannot support: employers who self-fund are systematically larger, younger, and healthier than those who do not, so measuring one group against the other captures selection as much as savings. The model that follows is built from cost components instead, each one traceable to a published source and each one stated so you can re-run it with your own vendor quotes. The calculator still does the harder job of estimating what your specific plan can recover. This paper does the narrower one of showing what the funding structure is worth on its own.

The retention bridge

Start with a fully insured premium and take out what self-funding removes. Then add back what self-funding costs. The difference is the structural advantage, and it is available on day one, before you change a single benefit or renegotiate a single contract.

EXHIBIT 5

Self-funding cuts the retention layer from about 12 percent of premium to about 9 percent



Sources: KFF Health Insurer Financial Performance in 2024, February 23, 2026, for the 88 percent group market loss ratio; NAIC Premium Tax Rate by Line, December 2025, for the premium tax component; market rate ranges for stop-loss, administrative, and network fees at a 1,000-life group.
Note: Component percentages are modeled illustrative values expressed as a share of an equivalent fully insured premium, not survey results. Stop-loss premium is shown gross of expected reimbursements, which understates the net advantage in a year with a large claim.

A worked example

Take an organization with 1,000 covered employees paying $18,500 per employee per year, which is close to the market average Mercer reports for 2026.[6] Total plan cost is $18.5 million. Apply the bridge above.

Component	Fully insured	Self-funded	Difference
Expected claims	$16,280,000	$16,280,000	$0
Insurer risk margin	$555,000	$0	($555,000)
State premium tax	$333,000	$0	($333,000)
Carrier administration and broker	$1,332,000	$0	($1,332,000)
Stop-loss premium	$0	$906,500	$906,500
Third-party administrator fee	$0	$555,000	$555,000
Network access and compliance	$0	$222,000	$222,000
Total annual plan cost	**$18,500,000**	**$17,963,500**	**($536,500)**

Table 3. Modeled annual cost comparison, 1,000 covered employees. Figures are illustrative and rounded. Actual stop-loss and administrative pricing vary with group size, industry, geography, deductible selection, and claims history.

The base case saves $536,500 a year, or about $537 per employee, which is 2.9 percent of total plan cost. Run the same model with less favorable and more favorable vendor pricing and the range holds between 2 and 5 percent.

$370,000
Conservative case, 2 percent of plan cost

$536,500
Base case, 2.9 percent of plan cost

$832,500
Favorable case, 4.5 percent of plan cost

What it costs to get there

Implementation is a one-time cost, and a meaningful share of it can be absorbed by the administrator or broker if you negotiate for it. Budget the full range and treat anything you do not spend as a gain.

Cost category	Low	High
ERISA plan document drafting and legal review	$25,000	$60,000
Actuarial and benefits consulting	$30,000	$75,000
Systems integration, eligibility, and data feeds	$20,000	$60,000
Employee communication and open enrollment	$15,000	$40,000
Total one-time implementation	**$90,000**	**$235,000**

Table 4. Planning estimates for a 1,000-life implementation. Ranges reflect typical market quotes and should be validated against your own proposals.

Against a conservative $370,000 of annual savings, a high-end $235,000 implementation pays back in roughly eight months. Against the base case, payback lands closer to four. In every scenario we modeled, the investment is recovered inside the first plan year. That is

the honest headline, and it is a stronger one than a return percentage that no CFO will believe.

The second layer, and why it is conditional

The structural savings are the floor. The larger opportunity comes from what you do with the claims file you now own. Four levers account for most of it.

- **Payment integrity.** Auditing claims against clinical and coding rules before and after payment. Duplicate billing, unbundling, and improper facility coding are common and recoverable.
- **Pharmacy contracting.** Specialty drugs now exceed half of net pharmacy spend on under 2 percent of utilization.[17] Pass-through pricing, rebate transparency, formulary control, and an enforceable audit right are all available to a self-funded plan and rarely to a fully insured one.
- **Site of care and price variation.** The same procedure can cost several multiples more at one facility than another in the same market. You cannot steer what you cannot see.
- **High-cost claimant management.** Early identification and care navigation for the members who drive the majority of spend.

We are deliberately not attaching a percentage to this layer. The magnitude depends entirely on your population, your current contracts, and how much waste is already in your plan. A plan that has never been audited will find more than one that has. The right way to size it is to run the analysis on your own 24 to 36 months of claims, which is the first step in the implementation framework in Section 6.

> *Self-funding does not save you money. It gives you the standing to go find it.*

SECTION TAKEAWAYS

1. **The structural advantage is 2 to 5 percent of total plan cost**, roughly $370,000 to $830,000 a year for a 1,000-employee plan, available on day one.
2. **Implementation runs $90,000 to $235,000** and was recovered inside the first plan year in every scenario we modeled, with payback between four and eight months.
3. **The second layer is larger and conditional.** Size it on your own 24 to 36 months of claims. A percentage quoted before anyone has seen your claims is a starting hypothesis, not a finding.

SECTION TAKEAWAYS

1. **Every contract is now a disclosure event.** CAA 2026 applies to any service agreement entered into, extended, or renewed after February 3, 2026.
2. **The standing wall cracked in March 2026.** *Stern v. JPMorgan Chase* sent prohibited transaction and drug overpayment claims into discovery.
3. **Fiduciary exposure is not created by self-funding.** You already have it. What changes is whether you can document what you examined and when.

SECTION 4

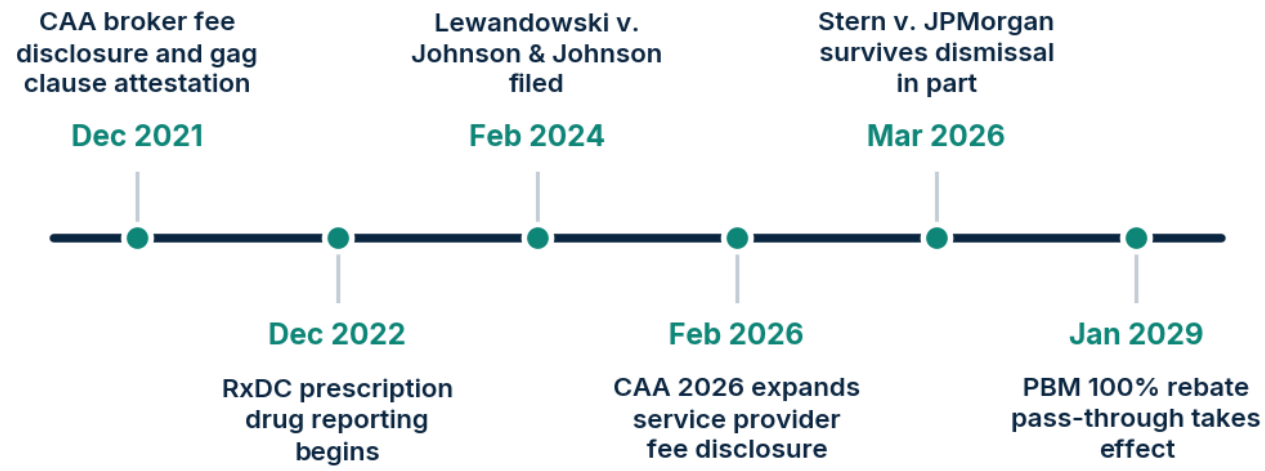
The 2026 fiduciary environment

Three years ago, health plan fiduciary duty was a theoretical concern. It is now a litigated one, and the disclosure rules changed materially in February 2026. This section is the part of the paper most likely to be new to you.

If you sponsor a group health plan, you are already an ERISA fiduciary with respect to plan administration. That is true whether you self-fund or not. What changed is the volume of information you are now entitled to, the volume you are now expected to act on, and the willingness of courts to let participants ask what you did with it.

EXHIBIT 6

The compliance and disclosure calendar for group health plans, 2021 to 2029



Sources: Consolidated Appropriations Act, 2021 and 2026; CMS gag clause attestation guidance; Trucker Huss, March 3, 2026; Groom Law Group, June 3, 2026; Georgetown Health Care Litigation Tracker.

What CAA 2026 changed

The Consolidated Appropriations Act of 2026 was signed on February 3, 2026. Under the prior rule, only brokers and consultants had to disclose their compensation to plan sponsors. The new law extends direct and indirect compensation disclosure to substantially all group health plan service providers, including plan design, recordkeeping, pharmacy benefit management, and administration. It applies to any contract entered into, extended, or renewed after February 3, 2026. A service provider that fails to comply renders the arrangement unreasonable, which strips its exemption from the ERISA prohibited transaction rules.[23,26]

Two further provisions take effect on January 1, 2029. Pharmacy benefit managers must remit 100 percent of rebates, fees, and other remuneration to the plan or issuer. And they must provide semiannual reports to employers with 100 or more employees covering drug-level pricing, rebates received, and participant cost sharing.[23]

> **THE PRACTICAL IMPLICATION**
>
> Every service agreement you sign or renew from now on is a disclosure event. If you are going to self-fund, negotiate the compensation disclosure, the data ownership clause, and the annual audit right into the original contract. You have far more bargaining power at the outset than you will at renewal.

The proposed PBM fee disclosure rule

The Department of Labor published a proposed rule on January 29, 2026 that would require pharmacy benefit managers and affiliated brokers and consultants to disclose direct compensation, manufacturer payments, spread compensation, copay clawbacks, price protection arrangements, and the net cost to the plan of each formulary drug by pharmacy channel. Self-funded plans would receive an annual right to audit the service provider for the accuracy of those disclosures, an obligation to request correction within 90 days of a failure, and a duty to notify the Department if the provider does not comply. The comment period closed on March 31, 2026.[24]

Published analyses differ on the proposed applicability date, with some reporting plan years beginning on or after July 1, 2026 and others January 1, 2027. Confirm the current status with counsel before relying on either. As of this writing we have found no final rule.

Where the litigation stands

Three cases define the landscape.[27,28] Through 2025, employers won consistently on standing, meaning courts held that participants could not show a concrete injury from alleged excessive plan costs. That wall showed its first crack in March 2026.

Case	Status	Why it matters
Lewandowski v. Johnson & Johnson D.N.J.	Dismissed for lack of standing on November 26, 2025. Final judgment January 12, 2026. On appeal to the Third Circuit since January 16, 2026.	The first major health plan fee case. The court found the injury theory speculative and noted the complaint addressed only 57 drugs within a much larger formulary.
Navarro v. Wells Fargo D. Minn.	Dismissed a second time in early March 2026. On appeal to the Eighth Circuit. Appellee brief due August 28, 2026.	The court found no causal link between alleged PBM pricing and participant premiums, noting fiduciaries retained discretion over contribution rates.
Stern v. JPMorgan Chase S.D.N.Y.	Survived the motion to dismiss in part on March 9, 2026. Prohibited transaction claims and out-of-pocket drug overpayment claims proceed to discovery.	The case to watch. Benefit design claims were dismissed on settlor grounds, but specific, well-pleaded drug cost claims cleared the standing bar.

Table 5. Principal ERISA health plan fee litigation as of August 19, 2026. **Sources:** Georgetown Health Care Litigation Tracker; Groom Law Group, June 3, 2026; Jones Day, May 6, 2026. **Note:** Reported dates for the second Navarro dismissal vary between March 3 and March 6, 2026. Appellate decisions in Lewandowski and Navarro are generally expected in 2027.

The pattern that emerges is specific. Generic allegations that a plan paid too much continue to fail. Well-pleaded claims tied to identifiable prescription drug overpayments, supported by concrete participant cost sharing, can now proceed. In December 2025, a coalition of twelve state financial officers separately wrote to Fortune 500 companies requesting payment integrity analyses of their health plan spending, opening a second front distinct from private litigation.[26]

The recurring calendar

- **Gag clause attestation.** Due December 31 each year through the CMS system. The next deadline is December 31, 2026. A third-party administrator can file on your behalf, but the legal obligation stays with the plan.[29]
- **RxDC prescription drug reporting.** Due June 1 each year for the prior reference year. The next deadline is June 1, 2027 for reference year 2026. Administrators typically request plan-level data in March or April.[30]
- **Mental health parity.** The 2024 final rule is under a non-enforcement policy announced May 15, 2025, covering only provisions new relative to the 2013 rule, pending resolution of the ERIC litigation plus 18 months. The statute, the 2013 rule, and the CAA 2021 comparative analysis requirement all still apply.[31]
- **No Surprises Act arbitration.** CMS issued the Federal IDR Operations final rule on May 28, 2026, cutting the administrative fee to $15 per party, requiring standardized claim adjustment codes, and expanding batching with a 50 line-item cap. Providers won 88 percent of the 2.6 million disputes filed in 2025.[8,32]

What this means for the funding decision

Self-funding does not create fiduciary exposure. Every plan sponsor already has it. What self-funding changes is your ability to answer the question. A fully insured employer asked to demonstrate prudent management of plan assets has a carrier summary report. A self-funded employer has the claims file, the fee disclosures, the audit rights, and a documented record of what it examined and when. In an environment where the question is now being asked in court, that difference is worth something the cost model does not capture.

SECTION 5

Managing the risk you take on

The failure mode for a self-funded plan is almost never the annual number. It is the month when three catastrophic claims land together and the reserve is not there.

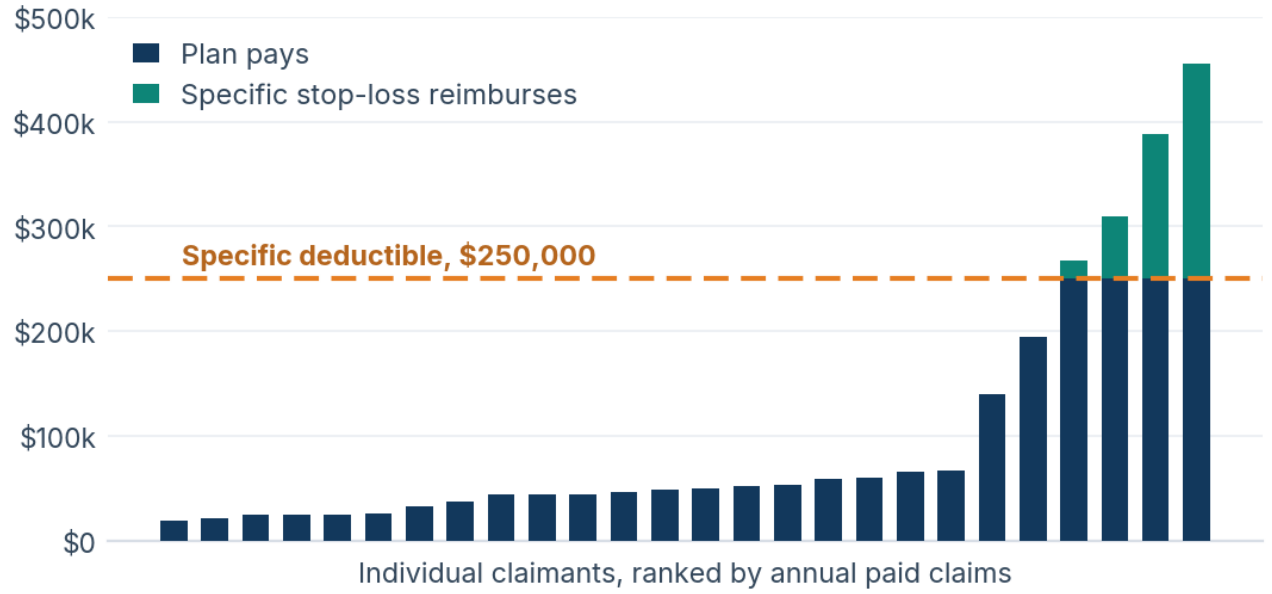
Stop-loss, in two layers

Stop-loss insurance caps what the plan pays. It comes in two forms, and a well-built program usually carries both.

Specific stop-loss protects against a single high-cost claimant. You choose a deductible, commonly between $100,000 and $500,000 depending on group size, and the carrier reimburses claims above it for that individual. Lower deductibles cost more premium and leave less variance. This is the layer that matters most for mid-size employers.

EXHIBIT 7

Specific stop-loss transfers the tail, not the base, of individual claims cost



Note: Illustrative distribution for a mid-size plan at a $250,000 specific deductible. Each column is one claimant. The plan retains everything below the line and is reimbursed for everything above it.

Aggregate stop-loss protects against total claims running over projection across the whole group. The attachment point is commonly set at around 120 to 125 percent of expected annual claims, though it is a market convention rather than a regulated standard and is negotiable.[21] For the 1,000-life example in Section 3, expected claims of $16.28 million would put a 125 percent aggregate attachment at roughly $20.35 million.

Aggregate coverage has become less central for larger self-funded groups, where credibility is high enough that total claims rarely breach the corridor and specific coverage carries most of the protective value. For a group under about 500 lives it remains worth buying.

THREE CONTRACT TERMS THAT DECIDE WHETHER STOP-LOSS WORKS

Contract basis. A 12/12 contract covers claims incurred and paid in the same twelve months and leaves a gap at transition. A 24/12 or paid basis closes it. Ask which you are buying.

Lasering. Carriers may assign a higher individual deductible to a known high-cost claimant at renewal. Negotiate no-new-laser and rate cap provisions before you need them.

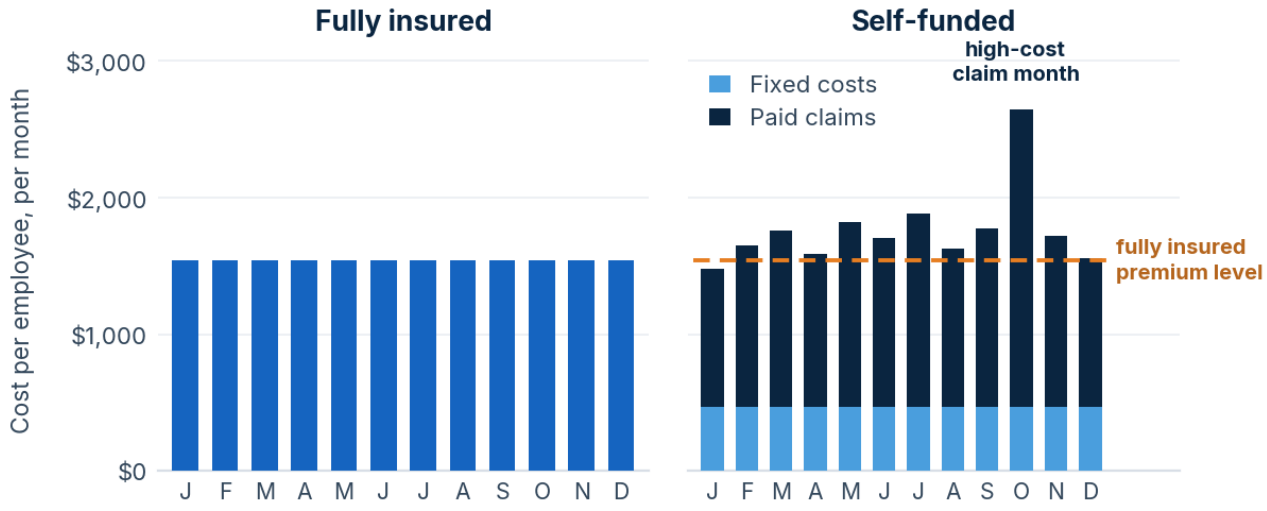
Disclosure at underwriting. Incomplete disclosure of known claimants is the most common reason a stop-loss reimbursement is denied. Full disclosure costs premium. Omission costs the claim.

Cash flow is the real exposure

A fully insured premium is twelve identical payments you can budget to the dollar. A self-funded plan pays claims as they clear, which means the monthly number moves with utilization, with the calendar, and with whoever happened to have surgery in October.

EXHIBIT 8

Self-funding trades a fixed monthly cost for a lower average and a wider range



Note: Illustrative monthly pattern for the modeled 1,000-life plan. Fixed costs comprise the administrative fee, network access, and stop-loss premium. The dashed line marks the equivalent fully insured premium level. Total annual self-funded cost is below the fully insured total, but seven of twelve months exceed it.

Notice what the exhibit shows. The self-funded plan is cheaper over the year and more expensive in most individual months, because the cheap months are cheaper by more than the expensive months are dearer. A finance team that budgets on the annual number and forgets the monthly one will meet a liquidity problem in a year that ends fine.

What to have in place before go-live

- **An operating balance of one to two months of expected claims.** For the modeled plan, expected claims of $16.28 million work out to about $1.36 million a month, so the target balance is $1.4 million to $2.7 million.
- **A committed line of credit** sized to at least one additional month, drawn only for claims volatility.
- **Incurred but not reported reserves** set by your actuary and revisited quarterly. Claims lag two to three months in most plans, so your first year understates true cost.
- **A documented stop-loss recovery procedure** with the administrator: who files, on what timetable, and what happens if a deadline is missed.

HOW WE CALCULATED THIS

Expected claims of $16,280,000 equal 88 percent of $18.5 million in total plan cost, matching the 2024 fully insured group market loss ratio. Divided across twelve months, that is $1,356,667. The one to two month reserve range follows standard actuarial practice for claims lag and is not a regulatory requirement. Your actuary should set the figure against your own lag pattern.

SECTION TAKEAWAYS

1. **Specific stop-loss carries most of the protection** for mid-size plans. Aggregate coverage still earns its place below about 500 lives.
2. **Terms beat price.** Contract basis, no-new-laser provisions, and disclosure standards vary more between carriers than premium does.
3. **Fund the reserve before go-live.** One to two months of expected claims plus a committed credit line. This is where self-funded plans fail.

SECTION 6

A 15-week implementation framework

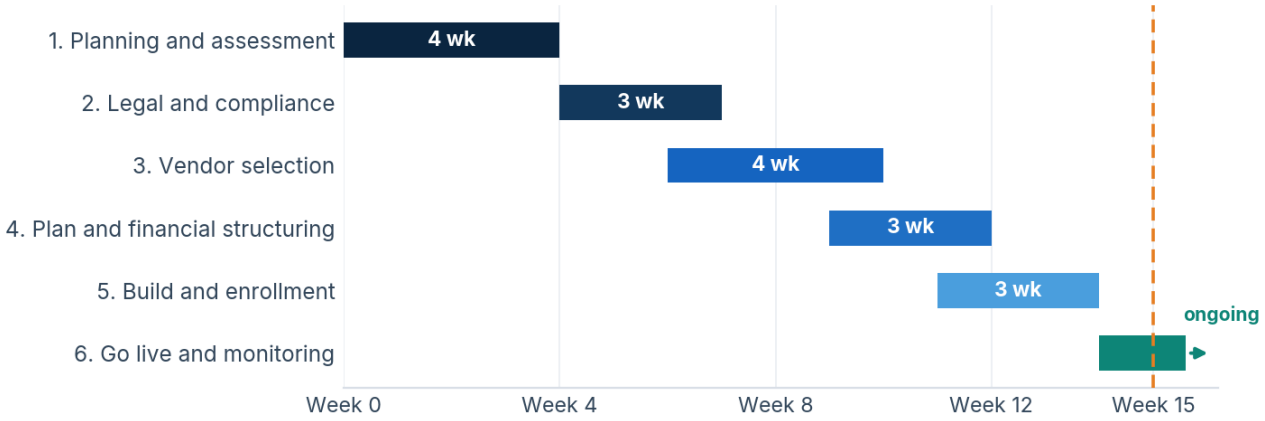
Fifteen weeks is achievable. It is not typical. Published guidance for a first-time transition ranges from six months to two years, and the difference is almost entirely about how much preparation happens before week one.

SET EXPECTATIONS HONESTLY

The framework below is our own implementation methodology, not an industry benchmark. Fifteen weeks assumes an executive sponsor with decision authority, an established broker or consultant relationship, 24 to 36 months of clean claims data already in hand, and a renewal date at least that far out. Remove any one of those and the timeline extends. The Phia Group, which publishes one of the more detailed transition guides, describes roughly two years as standard and six to twelve months as the accelerated path.[22]

EXHIBIT 9

Six phases, with vendor selection and financial structuring running in parallel



Source: Model Optimal Care implementation framework. Phase durations assume the prerequisites described above.

Phase 1. Planning and assessment, weeks 1 to 4

Everything downstream depends on this. Pull 24 to 36 months of historical claims and run the distribution, not the total. Identify your high-cost claimants and separate the ongoing from the resolved, because that determines your stop-loss underwriting and your lasering exposure. Profile population demographics and chronic condition burden. Then assess honestly whether HR and finance can absorb the administrative load.

Phase 2. Legal and compliance, weeks 5 to 7

Draft the ERISA plan document and summary plan description, and have counsel review both. Build the HIPAA privacy and security framework, including business associate agreements with every vendor that touches protected health information. Confirm the regulatory position in each state where you have members, and verify CAA and No Surprises Act compliance, including gag clause attestation and your RxDC reporting path.

Phase 3. Vendor selection, weeks 7 to 10

This overlaps Phase 2 deliberately. Issue the request for proposal to third-party administrators and evaluate on claims adjudication accuracy, data delivery format and frequency, member service metrics, and compliance capability, in that order. Negotiate stop-loss with at least three carriers. Select the pharmacy benefit manager on contract terms rather than on projected discount, and read the definitions section. Confirm network access arrangements.

> **CONTRACT CLAUSES TO SECURE IN PHASE 3**
>
> Plan data ownership stated explicitly, with a machine-readable extract on demand and on termination. Direct and indirect compensation disclosure for every service provider under CAA 2026. An annual audit right with a defined remediation window. Pass-through pharmacy pricing with 100 percent rebate remittance. Performance guarantees with financial consequences. Termination for convenience with a reasonable notice period.

Phase 4. Plan and financial structuring, weeks 10 to 12

Finalize the benefit structure against a competitive analysis of your labor market. Set the stop-loss attachment points using the claims distribution from Phase 1 rather than a rule of thumb. Establish the claims fund and calculate reserves with your actuary. Build the contribution strategy, and model what happens to it in a bad claims year.

Phase 5. Build and enrollment, weeks 12 to 14

Integrate eligibility and payroll with the administrator and test the feeds with real data before go-live. Run the communication campaign. Employees rarely care how the plan is funded, but they care intensely whether their doctor is still in network and whether the card works in January, so lead with those. Train staff on the new escalation paths and distribute member ID cards.

Phase 6. Go live and monitoring, week 15 onward

Launch with elevated member support for the first 60 days, because that is when the questions arrive. Deploy the performance dashboard and agree what you will look at monthly. Set up claims pattern analysis and early intervention protocols for emerging high-cost claimants. Schedule quarterly vendor performance reviews with the contract guarantees in front of you.

> *The plan document is not the deliverable. The monthly review meeting is.*

Where implementations go wrong

- **Selecting the administrator on price.** The fee difference between a good administrator and a poor one is a fraction of the claims difference their adjudication accuracy produces.
- **Underestimating the eligibility feed.** Bad eligibility data produces denied claims, angry members, and stop-loss disputes. Test it with production data, not sample files.
- **Treating stop-loss as a commodity.** Contract basis, lasering provisions, and disclosure standards vary more between carriers than premium does.
- **Going live without the reserve funded.** The claims do not wait for the budget cycle.
- **No owner after go-live.** A self-funded plan is an operating responsibility. If nobody owns the monthly review, the data advantage evaporates within a year.

SECTION TAKEAWAYS

1. **Fifteen weeks is our framework, not a benchmark.** Published guidance for a first-time transition runs six months to two years.
2. **Administrator selection is the decision that compounds.** It determines your data, and your data determines everything after year one.
3. **Name the owner before go-live.** The structural savings arrive automatically. Nothing else does.

SECTION TAKEAWAYS

1. **Two dimensions block most transitions:** cash position and claims history. Both are fixable inside a plan year.
2. **Level funding is a legitimate bridge** for employers below the full self-funding threshold, with the tradeoffs set out in Section 2.
3. **If you are already self-funded, the question inverts.** Not whether you can bear the risk, but whether you are extracting the value the structure makes available.

SECTION 7

Are you ready? A readiness assessment

Work through this with your broker or consultant. It takes about twenty minutes and it will tell you more than a savings projection will.

Dimension	Not ready	Developing	Ready
Group size	Under 100 covered employees	100 to 250 covered employees	Over 250 covered employees
Claims history	No detail available from the carrier	12 to 23 months of summary data	24 to 36 months of detailed claims
Cash position	Cannot fund one month of expected claims	Can fund one month, no credit line	Can fund two months plus a committed line of credit
Risk tolerance	Budget certainty is a board requirement	Some variance acceptable within a corridor	Comfortable with annual variance for a lower average
Internal capacity	No dedicated benefits owner	Benefits shared with other HR duties	Named owner with time allocated to plan management
Advisory support	No consultant, commission-only broker	Broker with limited self-funded experience	Fee-transparent advisor with self-funded book
Executive sponsorship	No decision authority identified	Interest without a mandate	CFO or equivalent sponsoring with authority
Population stability	Headcount swinging over 25 percent a year	10 to 25 percent annual variation	Under 10 percent annual variation

Table 6. Self-funding readiness assessment. **Note:** Group size thresholds are directional. Level-funded arrangements can bridge the gap for employers below the full self-funding threshold, with the tradeoffs described in Section 2.

> **WHAT THIS MEANS FOR A 5,000-LIFE EMPLOYER**
>
> At this scale you are almost certainly self-funded already, and the readiness question inverts. The right assessment is not whether you can bear the risk. It is whether you are extracting the value the structure makes available: whether anyone audits your claims, whether your pharmacy contract is genuinely pass-through, whether you have exercised an audit right in the last three years, and whether you could document your fee review if a participant asked. Section 4 is the section that applies to you.

How to read your result

Mostly ready. Move to a formal feasibility analysis on your own claims and target the next renewal that gives you at least fifteen weeks of runway.

Mostly developing. Close the specific gaps first. Data access and reserve funding are the two that most often block an otherwise viable transition, and both are fixable within a plan year. A level-funded arrangement is a reasonable intermediate step.

Any "not ready" in cash position or claims history. Do not proceed on the strength of a savings projection. These two dimensions are where self-funded plans fail, and no amount of structural advantage compensates for a plan that cannot pay claims in March.

SECTION 8

Recommendations

If you are considering the transition

1. **Model on your own claims, not on a benchmark.** Twenty-four to thirty-six months of detailed claims, run for distribution and high-cost claimant composition rather than totals. Every number in this paper is a starting point for that analysis, not a substitute for it.
2. **Fund the reserve before you sign anything.** One to two months of expected claims in an operating balance, plus a committed line of credit. This is the single most common point of failure and the easiest to prevent.
3. **Treat administrator selection as the decision that matters.** Adjudication accuracy, data delivery, and compliance capability first. Fee last. The fee spread between candidates is smaller than the claims spread their performance creates.
4. **Negotiate data rights and fee disclosure into the original contract.** Explicit plan data ownership, machine-readable extracts on demand and on termination, CAA 2026 compensation disclosure, and an annual audit right with a remediation window.
5. **Buy stop-loss on terms, then on price.** Contract basis, no-new-laser provisions, rate caps, and disclosure standards vary more between carriers than premium does.
6. **Name an owner for the monthly review.** The structural savings arrive automatically. Everything beyond them requires someone whose job it is to look at the data.
7. **Communicate what employees actually care about.** Network continuity, card delivery, and where to call. Funding mechanics belong in an appendix, not in the announcement email.

If you are already self-funded

1. **Document your fee review.** Given the March 2026 ruling in *Stern*, a written record of what you examined, when, and what you concluded is worth building now rather than after a demand letter.
2. **Exercise an audit right this year.** If you have never audited your claims or your pharmacy benefit manager, you do not know what your plan is paying for.
3. **Re-paper contracts at the next renewal.** Any agreement entered into, extended, or renewed after February 3, 2026 falls under the expanded CAA disclosure requirement. Use the renewal to add the terms you did not get the first time.
4. **Check your stop-loss contract basis against your claims lag.** A 12/12 contract on a plan with a three-month lag is leaving reimbursements uncollected.

For the market

Three changes would improve decision quality for everyone. Standardized, comparable performance metrics across administrators would make selection something other than a beauty contest. Risk pooling structures that extend genuine self-funding, rather than level funding, to employers under 250 lives would open the strategy to the segment that needs it most. And independent, non-vendor benchmarking of what self-funding actually saves would replace the unsourced figures that circulate today, including the one we removed from this paper.

The path forward

Self-funding is a mature strategy with a well-understood risk profile and a modest, reliable structural advantage. It is worth roughly 3 percent of plan cost on day one. It is worth considerably more over three years if you use the claims file it gives you, and nothing extra at all if you do not.

The 2027 trend projections are the steepest in fifteen years. The fiduciary standard tightened in February 2026 and is being tested in court right now. Employers who move deliberately, with their own data and honest expectations, will manage both. The ones who move on a headline number they have not tested against their own claims will find the arithmetic harder than they planned for.

> **NEXT STEP**
>
> Run the readiness assessment in Section 7 with your advisor. Then model the structure against your own plan at **analyze.health**. If it is useful to talk it through, you can reach me through **modeloptimalcare.com**.

BACK MATTER

About this analysis

Method

This paper synthesizes publicly available data rather than presenting original survey research. Cost trend figures are drawn from the published annual projections of six benefits consultancies. Enrollment, premium, and plan funding figures come from the KFF Employer Health Benefits Survey, which surveyed more than 1,800 employers with at least 10 workers for its 2025 edition. Macroeconomic figures come from the CMS Office of the Actuary. Regulatory and litigation status was verified against primary sources, agency guidance, and court docket trackers between August 14 and August 19, 2026.

The financial model in Section 3 is a component build, not a comparison of self-funded and fully insured employers. It starts from the published 2024 fully insured group market medical loss ratio of 88 percent, allocates the 12 percent residual across risk margin, premium tax, and carrier administration using ACA medical loss ratio structure and NAIC premium tax data, and replaces those components with market-rate stop-loss, administrative, and network fees for a 1,000-life group. Every component percentage is stated in the exhibit so the model can be re-run with different assumptions.

What changed from the first edition

First edition	This edition	Reason
63 percent of workers self-funded	67 percent	KFF 2025 survey supersedes 2024. Sample change noted in Exhibit 4.
$2,760 average savings per employee	Replaced with a component cost model	The original figure came from the analyze.health model, built on industry benchmarks. This edition derives savings from published cost components so a reader can audit each input.
20 to 40 percent spend reduction in year one	Reframed as plan-specific	Reductions of that scale depend on how much recoverable waste a plan already carries. The paper now directs readers to size it on their own claims rather than quoting a range.
1,000 to 2,000 percent first-year return	Replaced with a payback period	A return multiple invites disbelief even when the arithmetic holds. Months to payback is the measure a CFO actually uses.
Health spending 20 percent of GDP by 2032, from 17.3 percent in 2022	$5.7 trillion and 18.4 percent of GDP in 2025, reaching 20.6 percent by 2034	CMS 2025 national health expenditure data and 2025 to 2034 projections, released June 24, 2026.
Family premium over $24,000 in 2024	$26,993 in 2025	KFF 2025 survey.
8.5 percent 2025 trend, 84 percent of employers acting	Refreshed to the 2026 and 2027 forecast round	The 8.5 percent belonged to an earlier forecast cycle. Six consultancies have published since.
Specialty drugs 40 to 50 percent of pharmacy spend	52 percent	Navitus 2026 Drug Trend Report.
Chronic conditions 86 percent of spend	Removed	CDC now states 90 percent "for people with" chronic and mental health conditions, a different claim. The widely used paraphrase was rated false by PolitiFact in February 2026, so the line was cut rather than restated.
State premium taxes 2 to 4 percent	Generally up to about 2 percent	NAIC Premium Tax Rate by Line, December 2025.
15-week timeline presented as a benchmark	Attributed as the MOC framework, with published ranges alongside	Naming it as our methodology is both more accurate and better branding than presenting it as an industry norm.

Table 7. Change log, first edition to second edition.

Limitations and caveats

This report should be read as a whole. Individual sections and exhibits should not be taken out of context.

- **The financial model is illustrative.** It is built on published averages for a hypothetical 1,000-life employer. Your stop-loss pricing, administrative fees, network charges, and claims experience will differ, potentially by a wide margin. Nothing here substitutes for an actuarial analysis of your own plan.
- **Self-funding increases variance.** The model shows a lower expected cost. It does not promise a lower cost in any given year. A bad claims year under a self-funded plan costs more than the fully insured premium would have, which is the risk you are being paid to take.
- **Vendor pricing assumptions are market ranges, not quotes.** The stop-loss, administrative, and network percentages in Exhibit 5 reflect typical pricing at a 1,000-life group. Smaller groups pay materially more as a share of spend.
- **Regulatory status changes.** The proposed DOL pharmacy benefit manager disclosure rule had not been finalized as of August 19, 2026, and published analyses conflict on its applicability date. The mental health parity non-enforcement policy could be revised. Confirm current status with counsel.
- **Litigation outcomes are unresolved.** Appeals in *Lewandowski* and *Navarro* are pending, with decisions generally expected in 2027. *Stern* survived a motion to dismiss, which is not a ruling on the merits.
- **The KFF adoption figures are not directly comparable year over year.** The 2025 survey covered firms with 10 or more workers where earlier editions covered firms with 3 or more.
- **This is not legal, tax, actuarial, or investment advice.** It is general information for planning purposes. Consult your own counsel, actuary, and advisors before acting on anything in it.

BACK MATTER

Notes

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BACK MATTER

About the author

Jude Odu is the author of *Model Optimal Care: End U.S. Healthcare Waste, One Health Plan at a Time*.

He has spent his career building analytics that show self-funded employers where their health plan dollars actually go. His work centers on payment integrity, pharmacy spend, price variation, and the fiduciary obligations that come with sponsoring a health plan. He writes The MOC Brief, a twice-weekly briefing on employer health costs and policy, and speaks regularly to benefits, finance, and self-funding audiences.

Reach him through **modeloptimalcare.com**.

About Model Optimal Care

Model Optimal Care is a framework for reducing waste in employer health plans through measurement rather than benefit cuts. It holds that most of the excess cost in a self-funded plan is visible in the plan's own claims data, and that the sponsor's job is to look. The book, the course, and the analytical tools all follow from that position.

Related resources

- **Interactive cost model.** Model the funding structure against your own plan size, industry, and premium at analyze.health.
- **The MOC Brief.** A twice-weekly briefing on employer health cost and policy developments, including the regulatory calendar in Section 4.
- ***Model Optimal Care*, the book.** The full framework, with chapters on payment integrity, pharmacy contracting, price transparency, and fiduciary duty.

On sourcing. Every figure in this paper traces to a note. Modeled values are labeled as modeled and their components are shown, so any assumption can be replaced with your own. Where published sources conflict, the conflict is stated in the exhibit note rather than resolved silently.

Suggested citation. Jude Odu, *Becoming Self-Funded: A Strategic Framework for Employer Health Plans*, 2nd ed. (Model Optimal Care, August 2026).

Disclaimer. This publication is for general information purposes only. It does not constitute legal, tax, actuarial, accounting, or investment advice, and it does not create an advisory relationship. Employers should consult their own counsel, actuary, and benefits advisors before making decisions about health plan funding. Projections and modeled figures are illustrative and will not align with any particular plan's experience. Third-party sources are cited as published; their accuracy is not independently audited here.

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