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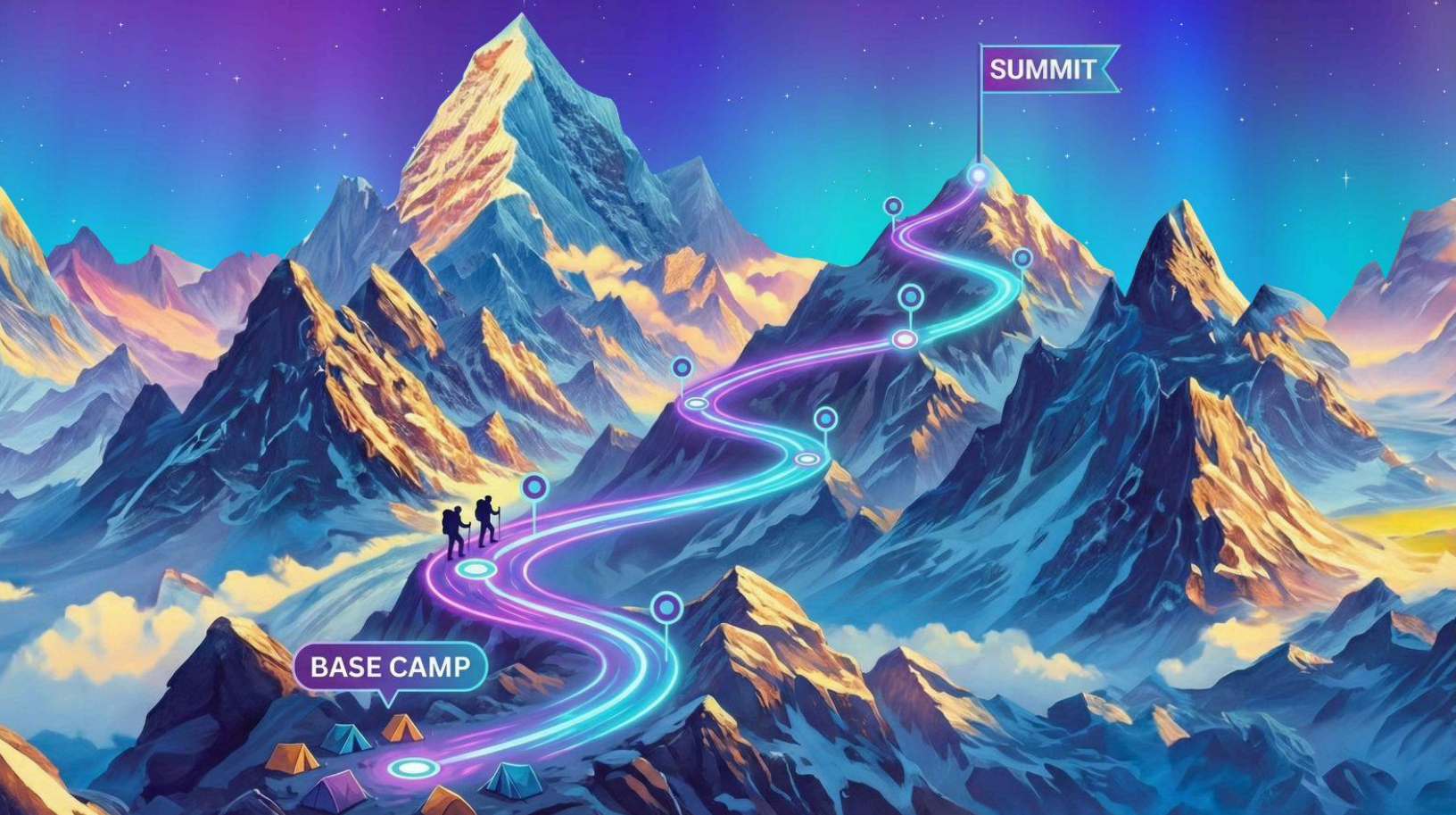
# THE SELF-FUNDING EXECUTIVE PRIMER

## Your Sherpa Guide to Taking Control of Healthcare Costs, Unlocking Data Transparency, and Funding Benefits with Intention.

Intelligent Insurance for Employers Who've Had Enough of the Status Quo



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# A Message from Our Founder

We didn't write this guide to impress anyone. We wrote it to liberate employers from confusion, from inflated costs, from outdated models, and from the fear of stepping off the beaten path.

At Triforta, we've seen the worst of the broken healthcare system. We've seen businesses punished for doing the right thing, HR leaders burned out from fighting with faceless carriers, and CFOs stuck in a budgeting hamster wheel they can't escape. We've stood in the fire with our clients. And we've built this guide as a torch to help others find their way out.

This isn't just another white paper. It's a field-tested blueprint. A compilation of years of trench work, legal reviews, vendor audits, strategy sessions, late-night spreadsheets, and real human conversations with real people who care about doing right by their employees.

Our mission is simple: Fix Healthcare. For Good.

That means walking with employers through the messy middle addressing their fears, giving them language to talk to their internal teams, and equipping them with smarter strategies to take control of their plan.

We believe:

- That the current system is unsustainable.
- That most brokers are misaligned.
- That self-funding is not radical it's rational.
- And that control isn't just possible. It's necessary.

But more than anything, we believe in passing down what we've learned. No gatekeeping. No expectations. Just honest, no-BS advice from people who've been there.

This guide exists because the right information can be the difference between a breakthrough and a breakdown. It's written for the HR heroes, the financial stewards, the internal counsel warriors, and the operational architects who know their current plan is failing but don't yet know where to start.

This is your start.

With deep respect for your role, and an open invitation to reach out

**Rodney Mattos, Sr.**
Founder & CEO, Triforta

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## About This Guide

This guide was created to do more than just explain how self-funded health plans work. It was crafted to:

- Demystify the journey from fully insured to fully empowered.
- Ease concerns of legal, finance, and HR teams with clear, compliant language.
- Highlight what matters cost containment, transparency, control, and better outcomes.
- Debunk myths and expose outdated broker tactics still shackling employers.
- Answer the real questions every stakeholder asks before making the move.

Inside, you'll find:

- Battle-tested definitions and terminology explained in plain English
- Legal talking points for internal counsel
- Sample plan language and fiduciary best practices
- Common FAQs by department
- Printable checklists and conversation guides
- A healthy dose of truth-telling

Whether you're an employer with 50 employees or 5,000, this guide was built with you in mind.

You deserve control.

Your employees deserve better.

Let's build it together.

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# Self-Funding Executive Primer

## Section 1: Executive Summary The Cost of Staying Fully Insured

**"It's not just healthcare. It's your second-largest expense. And it's quietly bleeding you dry."**

Most employers don't *choose* the fully insured model.
They inherit it. They accept it.
Because it's what's always been done.
Until they realize what it's really costing them.
Fully insured plans aren't just expensive.
They're opaque. Rigid. Misaligned.
They're built on a model where carriers make more money when costs go *up* and they hold all the cards.
Every year, you receive a spreadsheet full of carrier logos, rate increases, and "negotiated discounts."
And every year, you're told to pick your poison.
No transparency. No claims detail. No strategic levers to pull.
And worst of all? No accountability.
Your CFO wouldn't accept that from a supplier.
Your General Counsel wouldn't sign off on that from a contractor.
So why do we accept it when it comes to our second-largest budget line?

### The Quiet Margin Bleed

Fully insured carriers are masters of optics.
They talk in discounts, not dollars. They bury cost trends inside pooled renewals.
They own the PBMs. The hospitals. The imaging centers. The home infusion clinics.
Every claim that leaves *your* plan becomes revenue for *their* subsidiaries.
And you're locked out of the data.
Because if you could see the truth, you'd challenge it.

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## The Executive Wake-Up Call

Smart employers are waking up.
They're no longer asking, "What's our renewal?"
They're asking, "Why?"
They're done with 12-month rate cycles and 30-minute renewal meetings.
They're rejecting misaligned incentives.
They're demanding ownership, transparency, and control.
This eBook is for those employers.

For the CEOs, CFOs, COOs, and General Counsel ready to rethink the broken playbook and start treating their health plan like a strategic asset, not a sunk cost. Because the moment you shift from buyer to owner, everything changes.

**What's inside:**

- Why your current model keeps failing and who it's designed to protect
- What self-funding *really* means (it's not just for 500+ life groups)
- Legal considerations and fiduciary exposure most execs overlook
- Real case studies of employers who took the leap and reaped the rewards
- Step-by-step roadmap to transition with confidence

This is how you win back control.
Welcome to the start of your better benefits blueprint.

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## Section 2: Breaking Down the Cost Drivers Where the Money Goes and Why It's Going There

**"Fully insured plans don't pay claims. They pay profits."**

Let's be clear: healthcare costs haven't exploded because Americans suddenly got sicker. They've exploded because the incentives in the system reward higher spending, not smarter care.

And the fully insured model is the delivery mechanism.

### Hidden Cost Driver #1: Administrative Bloat

In the fully insured model, **up to 20% of your premiums** go toward administrative costs. Under ERISA guidelines, carriers are only required to spend **80–85%** of premiums on claims (the Medical Loss Ratio rule). But here's the catch: the definition of a "claim" is intentionally broad.

So when a carrier **owns the hospital**, the **pharmacy benefit manager (PBM)**, and even the infusion clinic guess what happens?

They're paying themselves.

Take a common example: a $23,000 MRI. That same scan could be performed for roughly $500 at a freestanding facility. But the carrier-owned hospital billed it at 46x the market rate and your plan paid it.

It still counted as a "claim" under MLR rules.
But it was really just **revenue transfer inside the machine**.

## Hidden Cost Driver #2: Pharmacy Benefit Games

The PBM business is one of the most misunderstood, yet profitable, components of the healthcare system. Fully insured carriers own their own PBMs and use them to **control formulary access**, **inflate prices**, and **collect hidden rebates**.

- The most expensive drugs stay on the formulary, while cheaper alternatives are buried.
- Manufacturer rebates are collected but often **not shared** with your plan.
- Spread pricing means the PBM bills the plan **$1,200 for a drug** they reimbursed the pharmacy **$200** for.

All of this happens **behind a black curtain**.
You can't audit it. You can't question it.
You just get the renewal.

## Hidden Cost Driver #3: Pooled Risk with No Accountability

Most employers are lumped into carrier risk pools where the sickest groups raise rates for everyone.

**Here's the trap:**

- You get a "pooled" renewal with no claim detail.
- You can't reward your group for running well.
- You can't defend yourself if you're being rated up unfairly.
- You're stuck unless you leave.

We've seen 40-life companies get hit with 25% increases despite having no large claims and below-average utilization. And when they ask, "Why?" they're told: **"It's the pool."**

No accountability. No leverage. Just margin erosion.

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## Hidden Cost Driver #4: Plan Design Misalignment

Fully insured carriers sell one-size-fits-all plans designed for **carrier efficiency**, not **employer outcomes**.

- Network contracts favor their owned providers, not value-based care.
- Copays steer members to higher-cost sites of care.
- Plan designs aren't built to manage chronic conditions, incentivize smarter choices, or prevent downstream costs.

It's a plan that's working... just not for you.

## Case Example: Company CFO & the $23,000 MRI

Let's revisit the MRI story.
A Company employee needed an MRI. The plan fully insured at the time approved the scan through a hospital billing $23,000. The employee's share? $4,500 out of pocket. But in a self-funded plan, that employer could've:

- Directed care to a freestanding center at **$500** total.
- **Eliminated the employee's share** completely.
- **Reviewed and challenged the charge** before payment.
- **Educated** the employee about future options and savings.

The result? A $22,500 win for the plan, and a better experience for the employee.
This is the power of control. This is what's at stake.

## Executive Takeaway: Follow the Incentives

If your vendor makes more when you spend more, they're not a partner.
They're a tollbooth.
The fully insured system is engineered to extract value not deliver it.
You're not managing a benefit.
You're managing a **margin loss mechanism** that's been normalized over decades.

But that changes the moment you step into ownership.

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## Section 3: The Case for Self-Funding (Without the Fear)

**Debunking the Myths. De-risking the Transition. Designing for Control.**
**"Self-funding isn't reckless. Staying fully insured without asking questions is."**

Let's set the record straight.
For too long, self-funding has been mischaracterized as "risky," "complex," or "only for large groups."

Those narratives serve one purpose: to keep you dependent. But here's the truth: modern self-funding is **smarter**, **safer**, and **more supported** than ever before. Especially when done *right*.

### Myth #1: "We're Too Small to Self-Fund"

Size isn't the barrier. Structure is.
You don't need 1,000 employees to start self-funding. We've helped employers with **as few as 30 lives** successfully exit the fully insured trap.

**The key? Design with intention.**

- Partner with an expert stop-loss underwriter.
- Build a strong base plan with measurable metrics.
- Join a high-performing risk pool, like a group captive or guided model.
- Use data from Day 1 not Year 3 to guide decisions.

*GuidedEdge*, our "Goldilocks" model for employers under 100 lives, was built for this exact scenario. It simplifies the path, minimizes volatility, and starts delivering control from the first month.

## Myth #2: "What If We Have a Bad Claims Year?"

Let's be honest you can have a bad year *today*, and you're still stuck paying next year's 20% increase with **no say**. Self-funding simply **makes the math visible**. And with the right tools, that visibility becomes leverage.

Here's how smart groups mitigate risk:

- **Stop-loss insurance** protects against catastrophic claims.
- **Captive structures** pool risk across similar employers.
- **Plan design** directs care to more cost-effective, higher-quality providers.
- **Early intervention tools** catch high-cost conditions before they spiral.

*In one case*, a 46-life logistics company joined a captive model and had a $137,000 NICU claim in year one. Thanks to stop-loss coverage and captive reserves, their renewal increase was **4%** not 40%. Fear didn't define their future. Strategy did.

## Myth #3: "Self-Funding Is Too Complex for Our HR Team"

If your HR team can manage open enrollment, payroll feeds, and compliance notices, they can manage a self-funded plan.
Especially now.

Modern self-funded platforms come with:

- Concierge TPA support
- Dedicated account teams
- Member advocacy services
- Simplified reporting dashboards

The right partner doesn't just sell a solution. They build the infrastructure **with you**. You're not in this alone. We've helped hundreds of HR leaders make the transition. And more often than not, their first comment is:
"I wish we'd done this years ago."

## Myth #4: "Fully Insured Is Safer"

Only if you believe in betting blind.
Fully insured plans shield you from data, prevent strategic action, and guarantee that **your premiums fund someone else's profits**.
That's not safety. That's stagnation.

Self-funding gives you:

- Access to claim detail
- Control over plan design
- Freedom to build in alignment with your people
- The ability to reward low utilization not subsidize high-risk groups

It's not about exposure. It's about **ownership**.

## Case Study: The GuidedEdge Mindset

One of our fastest-growing partners a 39-life engineering firm came to us with fatigue from 15% year-over-year hikes. They were told self-funding was too risky.

We built a custom **GuidedEdge plan**:

- **Fixed monthly costs** via level funding.
- A **reserve account** that accrued surplus for the employer.
- Immediate access to claims and Rx trend reports.
- Embedded member concierge to redirect care.

In year one, they **beat their expected claims by 18%** and **kept** the savings.
Fully insured would've just eaten that margin and reset the pricing clock.
Now they're asking about adding direct primary care and carving out specialty Rx.
Once employers see how this works, it's hard to unsee it.

## Executive Takeaway: Structure Beats Size. Always.

Don't let fear win the argument.

The real risk is leaving your plan on autopilot while costs climb and outcomes stall. The self-funded model has evolved. The support ecosystem is mature. And the strategy is proven. This isn't a leap it's a **ladder**. One step up from a system that no longer serves you.

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## Section 4: Blueprinting the Transition

***How Smart Employers Make the Move with Clarity, Control, and Confidence***

"This isn't just a change in funding. It's a change in philosophy."
Self-funding isn't a flip of a switch. It's a strategic shift that begins with asking better questions and ends with building a better plan.

Whether you're a 50-life manufacturer or a 300-life school district, your transition can be methodical, risk-aware, and tailored to your team's capacity. Let's walk through the blueprint.

### Step 1: Audit the Current State

You can't change what you don't measure. Most employers don't realize how little visibility they have until they start asking the right questions.

Start with:

- Total premiums paid in the last 3 years
- Carrier Medical Loss Ratios (MLRs)
- Rx utilization and rebate structure
- Renewal methodology (manual rate vs. experience-rated)
- Commission and override payments to the broker

✅ *Pro Tip:* If you're getting a "flat" renewal and your claims were low, the carrier may be pocketing the difference.

## Step 2: Identify Your Self-Funding Model

Self-funding isn't one-size-fits-all. There are **four primary paths**, and the best-fit depends on your goals, cash flow, and comfort with risk:

| Model | Group Size | Risk Profile | Best For |
|---|---|---|---|
| Level-Funded | 10–100 | Low | Simplicity + predictability |
| Group Captive | 45–1,000+ | Moderate | Shared risk, long-term savings |
| Unbundled Self-Funded | 100+ | Moderate–High | Full control + cost engineering |
| GuidedEdge (Hybrid) | 20–150 | Low–Moderate | Smart entry into self-funding |

*GuidedEdge* combines level-funding predictability with access to data, care navigation, and stop-loss power of a larger risk pool. Perfect for "first-time flyers."

## Step 3: Build Your Team

Self-funding is a team sport. Pick your partners with care:

- **Advisor/Broker:** Fee-based. Transparent. Not tied to carrier compensation.
- **TPA (Third Party Administrator):** Your day-to-day quarterback. Claims, COBRA, eligibility, and beyond.
- **PBM (Pharmacy Benefit Manager):** Choose one with pass-through pricing and **rebate sharing**.
- **Stop-Loss Carrier:** They insure your plan from catastrophic exposure. Vet them thoroughly.
- **Captive/Consortium (optional):** Join forces with like-minded employers to share risk and reward.

*Warning sign:* If your broker can't or won't show you options outside the BUCAH ecosystem (Blue, United, Cigna, Aetna, Humana) they're not your broker. They're the carrier's.

## Step 4: Design with Intent

Now comes the fun part: **You build the plan** not the carrier.

Design for:

- **Flexibility:** Offer tiered networks, incentives for smarter choices, DPC integration, or telehealth-first access.
- **Transparency:** Share data with your legal, finance, and HR leaders.
- **Alignment:** Tie your PBM, care navigation, and member support to your cost-containment goals.

*Case Example:* One of our mining clients introduced a $0 imaging copay **only at high-value centers**. Utilization shifted. Quality improved. Total imaging spend dropped 34%.

## Step 5: Prepare Your Internal Rollout

Your people don't need an insurance lecture. They need to know you're building a better plan for them.

The rollout should:

- Start 90 days before the effective date
- Include internal champions (HR, department heads)
- Offer clear, human-first messaging (i.e., "You'll pay less when you choose smarter care")
- Provide mobile tools or concierge access to guide their experience

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## Step 6: Redirect Savings to Long-Term Value

What you save, you keep and now you get to reinvest it.

Top-performing employers:

- Contribute more to HSA accounts
- Add mental health or DPC services
- Fund wellness stipends or gym memberships
- Bonus HR teams for achieving cost KPIs

***Example:*** One 61-life consulting firm rolled $85K in year-one surplus into a lifestyle spending account (LSA), giving employees $1,400 each for health-related expenses. Morale? Sky-high.

## Executive Takeaway: The Right Move, Made Right

The blueprint isn't magic. It's math + mindset.
You're not betting on a guess you're taking control of a line item that's likely **second only to payroll**. And with the right partners, plan design, and internal buy-in, you're not just changing funding mechanisms...

You're **changing the game**.

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## Section 5: Objections, Myths & Mindset Shifts

***Clearing the Fog Before You Make the Climb***

Let's face it self-funding has a PR problem.
Executives hear "self-funded" and immediately picture catastrophic claims, volatile budgets, and HR headaches. That's not strategy. That's fear-based inertia. And the cost of staying put? It's more than just premiums it's **compounding overpayment** and **lost opportunity**.
Let's tackle the biggest objections head-on.

### Objection 1: "We're Too Small to Self-Fund"

**Truth:** Size matters less than strategy.

Today's models are built for groups as small as **10 employees**, using level-funded plans or captives. These models smooth cash flow, cap your exposure, and still unlock the **data and decision rights** that carriers hide.

***Real Story:*** A 29-life architecture firm in Nevada joined a small group captive. Their first year savings topped $82K, but more importantly they got their first claims report ever. That clarity reshaped their leadership's entire benefits approach.

### Objection 2: "It's Too Risky"

**Truth:** Risk is always present. Intelligent employers decide how it's managed and who it ultimately rewards.

In a fully insured arrangement, pricing is driven by pooled assumptions and carrier economics. Margin is embedded upfront, and renewal outcomes are often disconnected from your organization's actual performance.

In self-funded models:

- You cap catastrophic risk with stop-loss
- You protect the downside with aggregate limits
- You monitor claims *as they happen*
- You drive behavior change in real time

*Mindset Shift:* Risk is manageable. Blindness is not.

## Objection 3: "My HR Team Can't Handle It"

**Truth:** Your TPA and partners carry the load. Your HR team just gets smarter tools.

With the right setup:

- Claims are paid by your TPA
- Questions are answered by a concierge team
- Enrollment, COBRA, eligibility **all handled for you**
- You get a dedicated client success manager to guide every step

✅ *Tip:* Offload the noise, keep the control.

## Objection 4: "We Don't Have Enough Time or Resources to Make a Change"

**Truth:** Most changes take **60–90 days** from decision to launch and the returns start immediately.

Plus, guided models like *GuidedEdge* reduce complexity by bundling key services:

- TPA + Stop Loss + PBM + Care Navigation = One simplified contract
- Prebuilt plan designs ready to go
- Plug-and-play tools for onboarding and employee education

*Case Snapshot:* A 37-life auto service group transitioned in 72 days. Year one ROI: 19%. Year two? 28%.

## Objection 5: "My Broker Says We're in a Great Plan"

**Truth:** Ask this: *Great for whom?*

If your broker is paid more when your costs go up what incentive do they have to challenge the carrier?

Ask yourself:

- Who owns your plan? You or the carrier?
- Do you have full access to claim-level data?
- Is your broker independent or embedded?

*Mindset Shift:* Loyalty should follow alignment. If your broker can't show you three self-funded alternatives, they're not looking out for you.

## Executive Reframe: This Isn't a Leap. It's a Climb with a Sherpa.

The best leaders don't wait for certainty. They build strategy into uncertainty. Self-funding is no longer a fringe idea. It's **mainstream** for CFOs and CEOs who want to **treat healthcare like a managed investment**, not a sunk cost.

"It's not about going self-funded tomorrow. It's about building the literacy and leadership to make smarter moves today."

You don't have to be an actuary. You just need to:

- Ask better questions
- Pick the right partners
- Let your plan serve your people not the other way around

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## Section 6: Closing Argument + Strategic ROI

***You're Not Buying a Plan. You're Building a Future.***

Let's level with each other.
You didn't rise to your role by doing what everyone else does. You're in leadership because you solve problems, you make bets, and you bet smart.

So here's the ask: apply that same discipline to the most expensive, least understood line item on your P&L, your health plan. Because fully insured is not a strategy. It's inertia, dressed up in an Excel sheet.

### The Strategic ROI of Owning Your Health Plan

Self-funding isn't about risk. It's about **return**.

You unlock three critical drivers of long-term value:

### 1. Financial Control

- Access *real-time claims data*, not guesses from last year
- Adjust benefits mid-year instead of waiting for renewal surprises
- Recover unused funds when claims run better than expected
- Gain the option to **earn underwriting profit** and share in **rebates**

*Snapshot:* One 48-life contractor received $68K in underwriting surplus their second year. That check funded a new safety incentive program. Win-win.

### 2. Talent Strategy

- Offer richer benefits at lower cost
- Customize plans for your workforce and geography
- Align plan design to retention and recruiting goals

✅ *Tip:* Want to attract skilled trades or retain millennial tech talent? Your health plan says more than your Glassdoor reviews.

### 3. Future-Ready Flexibility

- Integrate direct primary care, mental health, or MSK programs
- Carve out pharmacy, import biosimilars, and capture rebate dollars
- Control formulary and avoid the pricing games big carriers play

*Case in Point:* A 33-life engineering firm saved $172K by redirecting specialty pharmacy to a carve-out partner. Their HR leader called it the "most strategic thing we've ever done for employee well-being."

## The Cost of Doing Nothing

Every year you delay, your costs compound:

- 8%+ trend increases
- Surprise lasers and premium hikes
- Pharmacy spend climbing 12–20% annually
- Network discounts that don't actually reduce spend

Meanwhile, the carrier keeps grading their own homework. And the broker? Often paid more when your plan performs worse.

*Mindset Shift:* Playing defense on healthcare means losing slowly. Self-funding puts you back on offense.

## What Now?

Don't get overwhelmed by the buzzwords. Start simple:

1. **Run a Feasibility Analysis**
   → Let our team show you what self-funding could look like based on your real data.
2. **Choose the Right Model**
   → Guided options like *GuidedEdge* eliminate guesswork for smaller employers.
3. **Set a Strategic Timeline**
   → You don't have to flip the switch overnight. Set a 12–18 month vision and take the first step.

✅ *Tip:* Treat this like you'd evaluate a new ERP or facility lease strategically, not reactively.

## Our Perspective

We built this primer because we're tired of watching good companies bleed from bad plans.

You deserve more than a spreadsheet and a shrug at renewal time. You deserve a partner who can help you:

- Decode the hidden costs
- Take ownership of your data
- Align benefits with your business goals

And you deserve a healthcare strategy that performs like every other part of your operation with clarity, with discipline, and with ROI.

**"Self-funding isn't the end game. It's the starting point. Let's take the first step together."**

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## Section 7: Getting Started: The Roadmap to Self-Funding

So you're ready to move beyond the status quo. The decision's been made: it's time to take ownership of your health plan. Good. Let's talk about what happens next.

This isn't a blind leap it's a strategic shift. With the right partners, the right timeline, and the right playbook, your first 90 days can unlock a future of cost containment, data transparency, and long-term savings.

### The First 90 Days: Your Implementation Timeline

Think of implementation in three phases: **Planning**, **Partnering**, and **Deployment**.

### Phase 1: Planning & Strategy (Weeks 1–2)

- Finalize your effective date (ideally the first of a month).
- Clarify your goals: cost savings, better employee experience, data access, or all three.
- Engage leadership across HR, Finance, and Legal.

### Phase 2: Partner Alignment (Weeks 3–6)

- Select and onboard your Third Party Administrator (TPA).
- Choose a Pharmacy Benefit Manager (PBM) this is where 20–30% of savings typically live.
- Finalize stop-loss coverage with underwriting guidance.
- Build your custom Plan Document intentionally.

### Phase 3: Pre-Launch Prep (Weeks 7–12)

- Coordinate eligibility files and HRIS integrations.
- Launch internal communications for HR and employees.
- Prepare ID card generation, mobile apps, and member portals.

- Final plan audit and go-live readiness review.

## Key Roles in Your Self-Funded Ecosystem

You don't go it alone. Here's who you'll need on your team:

- **TPA (Third-Party Administrator)**: Your plan operations quarterback. Handles claims, eligibility, reporting, and customer service.
- **PBM (Pharmacy Benefit Manager)**: Don't just inherit one select one. Carve out. Structure rebates. Audit performance.
- **Stop-Loss Carrier**: This is your catastrophic claims safety net. Choose based on underwriting strength and renewal predictability.
- **Advisor/Consultant**: Your strategic guide. Must know ERISA, DOL, fiduciary obligations, and how to challenge misaligned vendors.
- **Legal**: Ensures plan docs, SPD language, and vendor contracts align with your goals and protect your fiduciaries.

## Internal Comms: Talking to HR and Employees

Even the best strategy can fail without the right message.
Don't just flip the switch tell the story. Here's what we advise our clients:

- **Educate early.** Host live sessions or webinars 4–6 weeks ahead of the plan start.
- **Reassure your people.** "You'll keep your doctors. We're just buying smarter."
- **Explain the "why."** Rising costs. Hidden games. And a better way forward.
- **Equip HR.** Provide FAQs, templated emails, benefit highlight sheets, and new member resources.

The transition is an opportunity to build trust not just save money.

## Your First-Year Checklist: Milestones That Matter

Here's what success looks like:

| Month | Milestone |
|---|---|
| Month 1 | Clean enrollment, live claims feed, ID card distribution complete |
| Month 2 | Launch member portal + mobile access; confirm TPA dashboard access for HR |
| Month 3 | Pharmacy claim audit + rebate visibility |
| Month 6 | Stop-loss midyear claims review; benchmark performance against expectations |
| Month 9 | Member feedback survey; early strategy discussion for next plan year |
| Month 12 | Full-year claims reporting; renewal options & performance-based adjustments |

This isn't a plug-and-play program. This is a leadership moment. With the right support and a guided roadmap, your organization can lead with confidence and win with data.

## About Triforta

**Fixing Healthcare. For Good.**

At Triforta, we didn't stumble into healthcare reform. We ran straight toward it eyes open, sleeves rolled up. We are not here to complain about the system. We're here to change it.

Our mission is bold, but it's simple: **Fix healthcare. For good.** That means empowering employers of all sizes to take control of their plans, eliminate waste, and reallocate dollars to what actually matters employee well-being and organizational growth.

We bring the tools. We bring the tech. But most importantly, we bring the **team** a seasoned, solutions-obsessed group of advisors, analysts, underwriters, and benefits architects. People who listen. People who innovate. People who care. We're not a carrier. We're not beholden to one. We answer to our clients. Period.

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## Who We Serve

We're proud to advise:

- ✔ **Mining and heavy industry employers** looking to protect their workforce and their margins in volatile markets
- ✔ **Automotive and skilled trades businesses** ready to replace outdated plans with data-backed solutions
- ✔ **School districts and municipalities** that need smarter ways to care for educators, staff, and retirees
- ✔ **Small and mid-sized businesses** (20–750 employees) who've been told self-funding isn't for them until now

If you've ever felt ignored by your carrier or confused by your broker, we get it. That's why we built a better path forward and we call it *Blueprints for Better Benefits*.

**Stay in the Know. Be Part of the Change.**

Subscribe to our newsletter and follow our journey as we fix insurance, one plan at a time.

- ➤ **Sign up for our LinkedIn newsletter:** *Blueprints for Better Benefits*
- ➤ **Listen to the podcast:** *The Rodney Mattos Show*
- ➤ **Start your guided consultation:** Contact Triforta

You don't have to take on the system alone. With Triforta, you'll have a guide, a game plan, and a partner who's in it with you for the long haul.

## Control the plan. Control the outcome.

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# Glossary of Terms: Know the Lingo, Control the Plan

## How to Use This Glossary

Understanding self-funded health plans starts with language. And if you want to **control the plan**, you have to first **decode the plan**. This glossary isn't just here to define insurance-speak. It's here to empower decision-makers.

From stop-loss mechanics to PBM contracts, from rebates to run-out claims each term you see here shows up in real-world financial statements, plan documents, and vendor proposals. Knowing what they mean, how they work, and why they matter equips you to challenge bad deals and build smarter ones.

Let this glossary serve as your decoder ring because when you understand the language, you take back control.

## Alphabetical Glossary

**Aggregate Deductible**
The total amount of claims a group must pay in a plan year before the aggregate stop-loss policy kicks in. This protects against unexpectedly high total claims across the group (vs. individual large claims).

**Aggregate Stop-Loss (ASL)**
A type of stop-loss insurance that protects a self-funded employer against high total claims exceeding a predefined aggregate deductible for the year.

**Allowance (Pharmacy)**
The maximum amount a plan will reimburse for a drug. If the retail price exceeds the allowance, the member may be balance-billed.

**Broker Compensation Disclosure**
A legal requirement under the Consolidated Appropriations Act (CAA) mandating

that brokers and consultants disclose their direct and indirect compensation to employers.

**Captive**
A group-based funding model where multiple employers pool their risk together under a shared reinsurance structure. Often used by small and mid-size businesses to stabilize stop-loss costs and gain access to better underwriting.

**Carve-Out**
When a benefit (e.g., pharmacy, mental health, dialysis) is removed from the bundled insurance carrier and administered separately often to save money or gain transparency.

**Claim Lag**
The time between when care is delivered and when the claim is paid. Self-funded plans need to manage this for cash flow and run-out tracking.

**Contractual Allowance**
The difference between the provider's billed charge and the plan's allowed amount. Often buried in explanation of benefits (EOBs) and misread as discounts.

**Cost Containment**
A set of strategies or vendors focused on reducing claim costs such as repricing, navigation, reference-based pricing, or fraud detection.

**Disclosure of Compensation (DoC)**
A federal rule requiring brokers and consultants to provide upfront details on all compensation received from insurance vendors.

**Employer Mandate (ACA)**
A requirement under the Affordable Care Act that employers with 50+ full-time equivalent employees offer minimum essential coverage or face penalties.

**ERISA (Employee Retirement Income Security Act)**
A federal law that governs self-funded health plans. It sets fiduciary standards and reporting requirements for plan sponsors.

**Explanation of Benefits (EOB)**
The statement a member receives after care is delivered. It outlines the billed amount, allowed amount, discounts, patient responsibility, and plan payments.

**Formulary**
A list of prescription drugs covered by a health plan. The structure is set by the PBM and often designed to maximize rebate revenue not necessarily clinical or cost-effective outcomes.

**Fully Insured Plan**
A traditional health insurance model where an employer pays a fixed premium, and the insurance carrier assumes all claims risk. Offers little transparency or control.

**Generic Drugs**
Bioequivalent versions of brand-name drugs, usually lower cost. Often favored in transparent PBM contracts, but deprioritized in rebate-driven models.

**GuidedEdge**
Triforta's proprietary self-funded platform for small groups. A "Goldilocks" approach that removes barriers to entry and includes implementation, TPA, PBM, and stop-loss support.

**Incurred But Not Reported (IBNR)**
Claims that have occurred but haven't been processed or paid yet. Important when transitioning from fully insured to self-funded to ensure run-out is covered.

**Independent Specialty Pharmacy (ISP)**
A non-carrier-owned specialty pharmacy partner used to dispense high-cost medications. Typically provides better pricing, white-glove support, and improved transparency compared to traditional PBMs.

**Individual Stop-Loss (ISL)**
Also called Specific Stop-Loss. Insurance that covers large claims from any single plan member once the claim exceeds the spec deductible.

**Laser**
An exclusion on a stop-loss policy where a known high-risk employee or dependent has a higher deductible (or is excluded entirely) from coverage. Often negotiated during underwriting.

**Maximum Reimbursable Amount (MRA)**
The highest amount the plan will pay for a procedure, service, or drug. Often used in reference-based pricing or pharmacy benefits.

**Minimum Essential Coverage (MEC)**
A type of limited plan that satisfies the ACA mandate but offers minimal benefits. Often used in compliance-only strategies not as a primary benefit offering.

**Minimum Value Plan (MVP)**
An ACA-compliant plan that meets minimum actuarial value standards (usually 60% of expected costs). Employers often use MVPs to avoid ACA penalties.

**Network Discount**
The percentage reduction negotiated between a carrier or TPA and the provider. Frequently misleading, as the "starting price" is often inflated.

**Out-of-Pocket Maximum (OOPM)**
The most an employee will pay in a year for covered services. Once hit, the plan covers 100% of eligible expenses.

**PBM (Pharmacy Benefit Manager)**
The third-party administrator that manages the drug formulary, network, claims, and rebate process. In self-funding, you choose your PBM and that choice impacts everything.

**PEPM (Per Employee Per Month)**
A standard metric for calculating costs in self-funded plans. Used in admin fees, stop-loss premiums, TPA pricing, and PBM models.

**PPO (Preferred Provider Organization)**
A type of network structure allowing employees to access a broad range of providers at negotiated rates. PPOs vary widely in quality, breadth, and pricing.

**Preferred Drug**
A drug listed on a formulary tier with the lowest cost-sharing. Can include brand or generic drugs, depending on the PBM's strategy.

**Reference-Based Pricing (RBP)**
A reimbursement model that pays a set amount (usually a multiple of Medicare) for services instead of relying on network discounts. Helps avoid inflated hospital billing.

**Reinsurance**
Another term for stop-loss insurance coverage that protects the employer from excessive claims exposure.

**Repricing**
The process of evaluating and reducing billed claims before payment. Used in cost containment strategies to catch errors, overcharges, or out-of-network bills.

**Rebate**
A post-sale payment made by a drug manufacturer to the PBM (and potentially shared with the employer). Highly opaque unless contracts are transparent.

**Run-Out Claims**
Claims incurred during the time a plan was active but processed after the plan term ends. These are especially important during carrier transitions or plan conversions.

**Self-Funding**
A health plan structure where the employer pays for actual claims (vs. paying premiums). Offers control, flexibility, and potential savings but requires good design and oversight.

**Shared Savings**
A cost-containment model where vendors split the money saved with the employer. Can align incentives or obscure pricing, depending on transparency.

**Specialty Drugs**
High-cost medications used to treat complex conditions. Often the most significant cost driver in pharmacy claims and an area ripe for strategic carve-outs.

**Spec Deductible (Specific Deductible)**
The fixed dollar amount a plan sponsor is responsible for paying on a per-participant basis before stop-loss coverage kicks in. It's a central element of financial risk strategy.

**Stop-Loss Insurance**
Protects the employer from large claims. Comes in two forms: Individual (specific) and Aggregate. Mandatory for most self-funded plans, especially small groups.

**Surplus Sharing**
When a self-funded plan has better-than-expected claims experience, some stop-loss carriers or captives return a portion of the unused premium to the employer.

**Third-Party Administrator (TPA)**
A company that processes medical claims, manages eligibility, and administers plan documents on behalf of the employer. Not the same as an insurance carrier.

**TPA Admin Fee**
The per-employee monthly or annual fee paid to the TPA to handle day-to-day operations of the plan, from claims adjudication to customer service.

**Transparency in Coverage Rule**
A federal regulation requiring health plans to publish machine-readable files showing negotiated rates and historical allowed amounts. An early step in opening the black box of healthcare pricing.

**Utilization Management (UM)**
The process of reviewing medical services for necessity, appropriateness, and cost. Includes prior authorization, case management, and medical necessity reviews.

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# Sample Plan Document Clauses

## 1. Medical Necessity Definition (Transparency-Aligned)

*"Medically Necessary" means services or supplies that are (a) essential to diagnose or treat an illness, injury, condition, disease, or its symptoms, (b) provided in accordance with generally accepted standards of medical practice, and (c) not primarily for the convenience of the patient, provider, or plan sponsor. The Plan reserves the right to independently review medical necessity through a third-party clinical partner not financially tied to the network or provider."*

**Why this matters**: Removes exclusive reliance on the carrier's discretion and reclaims plan control over approvals and denials.

## 2. Claim Fiduciary Delegation

*"The Plan Administrator retains ultimate fiduciary authority for claims determinations and appeals, and may delegate such authority to third parties, provided such delegation does not create a conflict of interest or violate ERISA fiduciary duties. All delegated parties must adhere to the Plan's written standards of review and transparency."*

**Why this matters**: Keeps employers ERISA-compliant but allows flexibility to offload tasks while maintaining oversight.

## 3. PBM Transparency Requirement

*"The Plan shall only contract with Pharmacy Benefit Managers (PBMs) that agree to disclose: (a) all sources of compensation including rebates, admin fees, and manufacturer support programs; (b) real-time drug costs; and (c) pass-through pricing for generics and brands, unless otherwise explicitly disclosed and approved by the Plan Sponsor."*

**Why this matters**: Forces a shift from opaque spread-pricing models to transparent Rx programs.

### 4. Surprise Billing Protection Clause

*"In the event of a surprise medical bill from an out-of-network provider for emergency or non-consensual care, the Plan will pay an amount deemed Reasonable and Customary as determined by third-party reference benchmarks, and hold the member harmless from additional collection attempts, subject to state and federal balance billing laws."*

**Why this matters**: Gives self-funded plans the ability to protect members from surprise bills without ceding control to overpriced network contracts.

### 5. Data Ownership and Audit Rights

*"All claims data, de-identified where necessary, is the property of the Plan Sponsor. The Plan retains the right to access, review, and audit such data including but not limited to medical, pharmacy, and vendor compensation data at any time upon reasonable request."*

**Why this matters**: Locks in data transparency as a fiduciary right and enables future vendor audits or benchmarking.

### 6. Conflict of Interest Prohibition

*"Vendors contracted with the Plan must disclose any financial relationships, incentives, or revenue-sharing arrangements that could impair their objectivity in recommending plan design, networks, clinical pathways, or vendor partners. The Plan reserves the right to terminate such contracts for breach of fiduciary alignment."*

**Why this matters**: Targets the financial misalignment often present with brokers and carrier-aligned vendors.

### 7. Reference-Based Pricing (RBP) Language

*"For designated services, the Plan will reimburse providers based on a multiple of Medicare or other benchmark-based pricing in lieu of PPO network rates. This benchmark-based reimbursement may vary based on provider type, location, and*

*market conditions. Members will be supported by a plan advocate in the event of balance billing or disputes."*

**Why this matters**: Empowers use of RBP as a reimbursement model without locking the plan into rigid PPO contracts.

### 8. Run-Out Claims Liability Coverage

*"The Plan shall remain liable for claims incurred during the active policy period but submitted after plan termination, up to a maximum of 180 days ('run-out' period), unless otherwise extended by stop-loss terms or administrative addenda."*

**Why this matters**: Defines the plan's legal responsibility post-termination and aligns with stop-loss protections.

### 9. Spec Deductible Definition

*"The Specific Deductible (Spec Deductible) is the per-member claims threshold that must be met before the Plan's stop-loss insurance reimburses further payments. This amount is reviewed annually and is not subject to mid-year adjustment without written Plan Sponsor approval."*

**Why this matters**: Makes sure mid-contract "lasers" or spec bumps can't sneak in unnoticed.

### 10. Legal Review Standard

*"The Plan shall regularly review its documents, disclosures, contracts, and fiduciary procedures in consultation with legal counsel specializing in ERISA and self-funded benefits to ensure continued compliance, risk mitigation, and alignment with the Plan Sponsor's stated mission."*

**Why this matters**: Demonstrates diligence, strengthens fiduciary defense, and keeps legal counsel looped in.

### 11. Vendor Replacement and Termination Clause

*"The Plan reserves the right to replace any vendor (including TPA, PBM, UR, stop-loss, or network partner) at any time with or without cause, provided a 30-day written notice is issued. All data, claims files, and case notes must be transferred securely and without fee within 10 business days of notice."*

**Why this matters**: Gives the employer flexibility to terminate underperforming vendors and ensures seamless transitions without vendor sabotage or delay.

### 12. Third-Party Compensation Disclosure Clause

*"All contracted vendors, including advisors, brokers, consultants, and intermediaries, must disclose in writing all direct and indirect compensation received related to the Plan, including bonuses, overrides, commissions, and revenue sharing arrangements."*

**Why this matters**: Prevents hidden incentives that create conflicts of interest, especially among brokers.

### 13. Annual Plan Performance Review Requirement

*"The Plan shall conduct an annual review of all vendor partners, claims utilization, and cost containment outcomes. The results of this review shall be documented and available to Plan Fiduciaries and, upon request, shared with applicable stakeholders including benefits committee members."*

**Why this matters**: Shows active fiduciary oversight and helps identify misaligned vendors or strategies early.

### 14. Stop-Loss Contract Review and Carve-Out Approval

*"All stop-loss contracts must be reviewed annually by the Plan Sponsor and legal counsel. No lasering, deductible adjustments, or contract exclusions shall be binding without express written approval from the Plan Sponsor."*

**Why this matters**: Protects against mid-contract changes and ensures stop-loss carriers can't sneak in coverage loopholes.

### 15. Independent Clinical Review Clause

*"In any appeal involving a denial of care or medical necessity, the Plan may seek an independent medical review from a clinician not affiliated with the TPA, carrier, or provider involved. This review will inform final appeal decisions."*

**Why this matters**: Adds objectivity to high-stakes claims disputes and mitigates accusations of rubber-stamping denials.

### 16. Fiduciary Insurance Requirement

*"The Plan Sponsor shall maintain Fiduciary Liability Insurance to cover defense costs and damages arising from alleged breaches of fiduciary duty under ERISA. Vendors and advisors shall also carry appropriate E&O coverage, naming the Plan Sponsor as an additional insured when applicable."*

**Why this matters**: Adds a layer of legal and financial protection for plan administrators.

### 17. Plan Asset Handling Protocol

*"Any funds held on behalf of the Plan (e.g., claim reserves, rebates, refunds) must be deposited into a trust account or custodial account maintained under the sole authority of the Plan Sponsor. Vendors shall not commingle Plan assets with operating capital."*

**Why this matters**: Prevents misuse of plan funds and satisfies ERISA "plan asset" handling requirements.

### 18. Member Advocacy Services Clause

*"The Plan shall provide advocacy and navigation services to assist members in resolving billing disputes, identifying cost-effective providers, understanding coverage options, and maximizing value-based care opportunities."*

**Why this matters**: Improves employee satisfaction and health outcomes while reducing administrative burden on HR.

## 19. Pharmacy Rebate Recovery Clause

*"All manufacturer rebates and formulary placement payments received by the PBM shall be passed through 100% to the Plan on a quarterly basis, net of any disclosed administrative fee. Rebate statements shall be auditable by the Plan Sponsor."*

**Why this matters**: Closes the black hole of hidden PBM revenue and returns funds back to the plan.

## 20. Direct Primary Care (DPC) Integration Clause

*"The Plan may designate preferred providers for Direct Primary Care (DPC), enabling members to receive unlimited primary care visits at no cost to the member. DPC fees shall be treated as preventive care and excluded from deductible accumulation."*

**Why this matters**: Encourages proactive care while minimizing downstream costs and ER usage.

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# Top 10 Broker Red Flags

*How to Spot Misaligned Incentives and Protect Your Plan*

## 1. Can't or Won't Explain How They're Paid

If your broker dodges questions about how they get paid, or gives you vague answers like "We're covered by the carrier," run. Transparency is the bare minimum, not a bonus.

## 2. Keeps Recommending the Same Carrier Year After Year

You're told every year that "the market just didn't improve," yet your carrier is still the same. That's not a coincidence it's inertia or worse, commission addiction.

## 3. Opposes Self-Funding Without Valid Analysis

Brokers who dismiss self-funding as "too risky" without showing you data are often the ones benefiting from your fully insured status. Fear is their favorite sales tactic.

## 4. Relies on a "Spreadsheet" as Their Only Value

A pretty renewal spreadsheet isn't strategy. If your broker can't talk you through cost-containment levers, risk segmentation, and multi-year planning, they're not a strategist they're a spreadsheet jockey.

## 5. Downplays Claims Data Transparency

If your broker doesn't insist on full access to your claims data or worse, tells you "you don't need it" they're either uninformed or protecting someone else's interest, not yours.

## 6. Avoids Putting Their Compensation in Writing

You asked for a formal compensation disclosure. Crickets. Or worse, "We'll get that over to you later." That's not forgetfulness it's intentional fog.

### 7. Hasn't Mentioned Fiduciary Risk… Ever

If your broker never brings up ERISA, fiduciary duties, or your personal liability, they're asleep at the wheel or hoping you are.

### 8. Doesn't Include Independent Legal Review in Major Changes

Plan amendments, carrier contract terms, stop-loss changes all should be vetted legally. Brokers who act as if "legal is overkill" are exposing your organization to risk.

### 9. Talks a Lot About Wellness, but Not About Waste

You'll hear about yoga and meditation before you hear about dialysis markups or pharmacy rebates. It's easier to distract you with perks than to fix the core cost drivers.

### 10. Refuses to Sign a Conflict-Free Agreement

When asked to sign an agreement declaring they'll represent your interests alone (not the carriers), they decline. That's not a neutral stance it's a blazing red flag.

## What to Do Instead

*Choose a broker who earns your trust and proves it with action.*

**Look for advisors who:**

- **Disclose every dollar** they make commissions, bonuses, overrides, and fees. You deserve to know who's paying them, and how much.
- **Bring you options**, not ultimatums. If you're not seeing multiple funding strategies, cost-containment levers, and vendor choices, you're not seeing the full picture.
- **Give you access to your claims data** and build reports that tell the story where your money goes, why, and how to change it.
- **Include independent legal review** as a standard part of plan design and contract vetting. Fiduciary protection isn't optional it's a requirement.

- **Educate your team, not confuse them.** A good broker will empower HR, Finance, and Legal to make better decisions not keep them dependent.
- **Sign a Conflict-Free Service Agreement.** If they say “no,” that tells you everything you need to know.
- **Proactively address fiduciary responsibilities.** They should be helping you design a plan that passes every ERISA test and avoids unnecessary liability.
- **Stay with you year-round.** Strategy doesn’t start at renewal. It starts day one and continues every month with insights, benchmarks, and improvements.

**Triforta Is Built Different**
We don’t get paid by carriers. We work for you.
We arm our clients with data, strategy, and leverage.
We don’t just build plans, we fix the broken ones.

**Want a Second Opinion?**
We offer free Plan Reviews with zero obligation.
Bring us your current broker contract, plan documents, or claims report.
We’ll show you what’s really there and what’s missing.

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# Legal, Compliance & HR: What Every Employer Needs to Know

## Executive Overview

If you're considering the move to self-funding, your legal team isn't just a stakeholder they're your co-pilot. Compliance, fiduciary risk, HIPAA, ACA regulations, and stop-loss contract terms all carry weighty implications that must be proactively addressed. This section equips internal counsel, compliance officers, and HR leadership with the knowledge they need to say "yes" to smarter funding without unnecessary exposure.

### Key Details for Your Legal Team

Use the following bullet points to frame early discussions and gain internal alignment:

- **ERISA Supersedes State Law**: Self-funded plans are federally regulated by ERISA, exempting you from most state mandates.
- **You Are the Fiduciary**: As the plan sponsor, the employer is legally responsible for plan oversight, documentation, and vendor selection.
- **ACA Compliance Still Applies**: Affordability and minimum essential coverage rules remain intact, execution simply shifts from carrier to employer via the TPA.
- **Stop-Loss = Safety Net**: High-cost claims are capped using individual (spec) and aggregate coverage legal should review policy language annually.
- **Documentation Matters**: Plan documents, SPD language, appeals protocols, and vendor SLAs should all be reviewed with legal oversight.
- **Risk Is Manageable with the Right Team**: With an experienced advisor, vetted vendors, and clear protocols, legal exposure is minimized and control is regained.

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## Frequently Asked Questions: Cross-Functional Self-Funding Concerns

These are the real-world questions your HR, Finance, Legal, and Compliance leaders are asking when exploring self-funding.

| Department | Question | Quick Answer |
|---|---|---|
| **Finance** | What if claims exceed our budget? | Covered by stop-loss insurance. Your liability per person (spec deductible) and total plan year (agg) are capped. |
| **HR** | Will this impact the employee experience? | No benefits can mirror (or exceed) current offerings, often with better networks, support, and transparency. |
| **Legal** | Are we exposed to lawsuits or fiduciary liability? | As the fiduciary, yes but risks are mitigated via documentation, indemnification, and adherence to ERISA protocols. |
| **Compliance** | What's our obligation under HIPAA and ACA? | The same as now. TPAs administer compliance, but you retain oversight. |
| **C-Suite** | What's our downside risk if it fails? | Minimal with proper safeguards. In worst-case scenarios, you can revert to fully insured in the next plan year. |

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# What Legal Needs to Know: A Conversation Guide for Counsel, HR, and Compliance Teams

## 1. Who's the Fiduciary Now?

Under a fully insured plan, the liability rests with the carrier. In a self-funded plan, the employer becomes the plan fiduciary under ERISA and is responsible for prudent oversight, documentation, and vendor management.

✅ *Tip: Fiduciary liability insurance and a strong advisor relationship help mitigate exposure.*

## 2. What Does ERISA Require?

ERISA mandates:

- A written plan document
- Claims appeal process
- Selection and monitoring of service providers
- Privacy and data handling per HIPAA
- Compliance with ACA affordability

✅ *Tip: Partner with ERISA-versed TPAs and legal advisors to maintain a compliant environment.*

## 3. What Happens if Claims Exceed Budget?

Stop-loss coverage protects against large individual claims and aggregate exposure.

- **Spec Deductible**: The threshold per member before stop-loss kicks in.
- **Aggregate Limit**: A ceiling on total plan year exposure.

✅ *Tip: Choose an experienced stop-loss partner and evaluate contract terms annually (lasers, triggers, run-in/out).*

## 4. What Legal Exposures Are Introduced?

Potential exposures include:

- ✔ HIPAA/data privacy violations
- ✔ Improper denial of claims
- ✔ Fiduciary breach under ERISA
- ✔ Vendor selection/oversight failure

✅ *Tip: Require indemnification language and SLAs in all vendor contracts.*

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## Common FAQs by Legal/Compliance/HR Teams

| Question | Answer |
|---|---|
| **Are we subject to state mandates?** | No. ERISA preempts state law for self-funded plans. |
| **How do we stay compliant with ACA?** | Minimum value and affordability rules still apply. Reporting shifts from carrier to TPA/Employer. |
| **Can we keep our current network?** | Yes. TPAs often offer access to national PPO networks or direct contracts. |
| **Who makes final coverage decisions?** | The Plan Document governs all coverage. The employer is the fiduciary; TPA administers. |
| **What is the run-out period?** | Time after plan year ends where claims from the previous year are still paid. Often 3-6 months. |
| **What is an ISP?** | Independent Specialty Pharmacy – used to bypass inflated PBM pricing for high-cost drugs. |
| **What is the Spec Deductible?** | The per-member claims threshold before stop-loss reimbursement kicks in. (e.g., $25K–$75K) |
| **Can we be sued over a denial?** | Yes, but adhering to ERISA's processes significantly limits liability. |
| **Do we need a reserve fund?** | Yes, typically 2–3 months of expected claims to ensure liquidity. |
| **What if the TPA fails to perform?** | Vendor contracts should include indemnity, SLAs, and audit rights. |

## Legal & Compliance Checklist

Before implementation, use this checklist to validate compliance posture:

- Review ERISA-compliant Plan Document & SPD
- Confirm Stop-Loss contract terms (lasers, triggers, run-in/run-out)
- Ensure indemnification and SLAs in vendor contracts
- Identify and document fiduciary decision-makers

- Validate HIPAA compliance and PHI data handling policies
- Confirm ACA compliance (Minimum Essential Coverage, affordability)
- Establish documentation protocols for appeals, denials, and audits
- Add or update Fiduciary Liability Insurance
- Review CMS reporting and COBRA administration protocols
- Engage ERISA legal counsel for final review before launch

## The Decision That Changes Everything

The cost of staying fully insured is quiet. Subtle. Hidden behind premiums and spreadsheets.

Until it's not.

Then one year, your renewal jumps. You scramble. HR panics. Finance flinches. Employees grumble. Leadership retreats to the same tired plan and the system wins again.

But not this time.

You've read the data. You've seen the strategy. You've unpacked the risks and now, you're ready to lead.

Self-funding is the most *business-owner move* you can make in employee benefits. It says:

- We're not afraid to be accountable.
- We believe our people deserve better.
- We care where every dollar goes.

It's time to build a plan that works for you, not the carriers. That's what leaders do.
You have a blueprint.
You have a partner.
You have the control.

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Let's get started.

## Your Next Move: The Triforta Executive Strategy Sprint

We're offering a **zero-risk, high-impact 14-day engagement** for qualified employers:

**The Triforta Executive Strategy Sprint includes:**

- ✔ **Custom Self-Funding Readiness Scorecard** (under 50 or over 500 lives tailored)
- ✔ **Plan Design & Funding Comparison** (including traditional, level, and captive models)
- ✔ **Rx Disruption Analysis** – uncover hidden waste in your pharmacy spend
- ✔ **Legal and Fiduciary Checklist** for Plan Sponsors
- ✔ **One-on-One Session** with Triforta's Founder & Captive Strategy Team

This is not a demo. It's **a real strategy playbook** designed to unlock six figures (or more) in potential savings.

And here's the kicker:

**If you don't get at least $100,000 of actionable ROI ideas from this sprint you don't pay a dime.**

**Ready to See If You Qualify?**

Book a confidential discovery call to take control of your healthcare costs today.

***Let's flip the script on your insurance plan.***
***Let's fix healthcare for good.***

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