

Self-Funded Health Plans: What Business Owners Need to Know

How Planstin + Graystone Make Self-Funding Safe, Compliant, and Cost-Effective

A self-funded health plan allows your company to **pay healthcare claims directly** instead of paying inflated premiums to an insurance carrier. For many employers, this model delivers greater control, flexibility, and long-term savings—especially when administered correctly.

How Self-Funding Works (Simplified)

Instead of sending fixed premiums to an insurance company, you set aside funds for employee medical claims. A Third-Party Administrator (TPA)—in this case, **Planstin**—handles the heavy lifting:

- Processes and adjudicates claims
- Manages contributions and billing
- Ensures ERISA, ACA, HIPAA, COBRA, and Section 125 compliance
- Coordinates provider networks (PHCS / Cigna options)
- Prepares all required plan documents (Plan Document, SPD, notices)

You only pay for healthcare as it's actually used—not for unused carrier premiums.

Protecting Yourself: Stop-Loss Insurance (Graystone)

Self-funding would be risky without stop-loss insurance.

Planstin uses its sister company **Graystone** to cap your exposure to high-cost claims:

- **Specific Stop-Loss:** Limits the cost per individual
- **Aggregate Stop-Loss:** Limits your total annual claims
- Tailored levels based on company size, health profile, and risk tolerance

This structure gives you **predictable ceilings** while retaining upside savings.

Section 125 Premium-Only Plan (POP)

A POP allows employees to pay their share of premiums **pre-tax**, lowering payroll taxes for both employer and employee. It's a core component of modern benefit design.

Employer Benefits:

- Reduced payroll taxes
- Higher employee participation

- Competitive advantage in recruiting
- Required for compliant pre-tax deductions

Employee Benefits:

- Lower taxable income
- Higher take-home pay

Planstin provides **Section 125 documents at no additional cost** and manages testing, updates, and IRS compliance.

ALE Requirements (If You Have 50+ Employees)

As an Applicable Large Employer (ALE), you must:

1. **Offer Minimum Essential Coverage (MEC)** to at least 95% of full-time employees
2. Ensure the plan is **Affordable + Minimum Value (MVP)** if you want to avoid all penalties
3. **File 1094-C & 1095-C** with the IRS annually

Penalties range from **hundreds of thousands per year** if ignored.

Planstin's ACA-compliant MEC and MVP plans help you **avoid both Part A and Part B penalties**.

Why Employers Choose Self-Funding with Planstin

- **30%+ potential savings** over traditional insurance
- **Full transparency** into claims and utilization
- **Flexible plan design** tailored to your workforce
- **Reduced taxes** through Section 125 integration
- **Risk protection** via Graystone stop-loss
- **Turnkey compliance:** Plan documents, IRS filings, COBRA notices, SPD/SBC, RxDC, CAA, ERISA support

This model lets you deliver better benefits at a lower, more predictable cost—while maintaining compliance and financial protection.

Bottom Line

Self-funding gives employers the control and cost savings they've never had with traditional insurance.

With **Planstin administering the plan** and **Graystone capping the risk**, businesses can safely move into a smarter, more efficient benefit model that rewards them—not the insurance carriers. If you'd like to learn more [click here](#).

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Self-Funding Overview

When a company opts for a **self-funded (self-insured) health plan**, it means the employer is taking on the responsibility of paying employees' medical claims instead of paying premiums to an insurance carrier^[1]. In a traditional **fully-insured** plan, an employer pays a fixed premium to an insurance company (like Aetna, Blue Cross/Blue Shield, or UnitedHealthcare) which then pays all the claims – often leading the employer to pay for services that employees may never use^[2]. By contrast, **self-funding** lets employers pay for healthcare expenses as they arise, which can improve cash flow and avoid pre-paying for unused coverage^[3]. Companies large and small are increasingly exploring self-funded benefits as a way to tailor plans to their workforce and potentially save on costs^[3].

How Self-Funded Insurance Works

Under a self-funded arrangement, the employer typically sets aside funds (often in a dedicated trust) to pay medical claims for employees and their dependents^[4]. The employer has greater control: for example, they can choose which healthcare **provider network** to work with (or even allow any provider) and design a plan that fits their employees' needs, rather than buying a one-size-fits-all policy. The plan must still follow certain federal rules (like ERISA, HIPAA, COBRA, etc.), but it is not subject to each state's insurance mandates in the way fully-insured plans are^{[5][6]}. This can simplify multi-state compliance and eliminate state premium taxes. Essentially, in a self-funded plan **your company pays claims as they come in, has flexibility in plan design and provider choice, and is governed primarily by federal law**; in a fully-insured plan, you pay fixed premiums to an insurer, abide by their network and coverage rules, and the plan is regulated by state insurance law. This flexibility allows tailoring benefits specifically to your workforce, rather than paying for extraneous benefits that may not get used.

Why Choose Self-Funding?

There are several potential advantages to self-funding your employee health benefits:

- **Cost Savings & Efficiency:** You pay for claims **only when they occur** instead of pre-paying hefty premiums for blanket coverage^[7]. This means you're not automatically funding the insurance company's profit margin or high administrative overhead. If your employees are relatively healthy, the savings can be significant over a fully-insured plan.
- **Avoiding Certain Taxes and Fees:** Self-funded plans are not subject to state insurance premium taxes and some ACA fees, which can reduce overall costs^[8].
- **Plan Customization:** You can **design a benefit plan tailored** to your employees' needs – choosing benefits that will actually be used and valued. For example, you

might include specific wellness benefits or exclude certain seldom-used services, all while remaining compliant with federal standards[9].

- **Provider Flexibility:** Unlike many off-the-shelf insurance products, self-funding lets you choose or negotiate access to healthcare providers. You could contract with a provider network that best matches your employees' locations and preferences, or even adopt reference-based pricing or direct primary care solutions to manage costs[10].
- **Transparency and Data:** With self-funding, you have access to detailed claims data. This transparency helps identify cost drivers (like high-cost procedures or medications) and informs wellness initiatives or plan adjustments. Instead of just receiving a renewal increase from an insurer, you can see *why* healthcare costs are what they are and take action.

It's worth noting that historically only large employers self-funded their health plans, but that trend is changing[3]. Today, even small and mid-sized businesses are exploring self-insurance as third-party administrators and innovative programs have made it more accessible. Employers with just a handful of employees up to enterprise-level companies can all consider self-funding if it fits their risk tolerance and goals.

Managing Risk with Stop-Loss Insurance

One of the biggest concerns with self-funding is the **financial risk**: what if one employee has a catastrophic claim (like a major surgery or cancer treatment) that costs hundreds of thousands of dollars? To protect against these worst-case scenarios, self-funded employers usually purchase **stop-loss insurance**. Stop-loss coverage reimburses the employer for claims that exceed a set threshold, capping the employer's exposure to large claims. In essence, it's insurance for your self-funded plan. For example, you might self-insure routine claims but have a stop-loss policy kick in for any individual claim above, say, \$30,000 (specific stop-loss) or if total claims for your whole group exceed a certain aggregate amount in a year (aggregate stop-loss).

Stop-loss coverage **makes self-funding feasible even for smaller companies**, because it prevents a single high-cost claim from jeopardizing the company's finances[4]. In fact, most small-to-medium employers *should not* self-fund without a stop-loss policy in place. Planstin's sister company, **Graystone**, specializes in making stop-loss coverage accessible for employers of any size[11]. Graystone was established to simplify risk management for self-funded plans, and by operating through a unique structure (domiciled with a federally recognized tribe), it can offer stop-loss policies that are easier to obtain and manage for companies that traditionally might have been too small for self-insurance[11]. Working with a stop-loss provider like Graystone means that even if you have a bad claims year, your costs are limited and predictable – you gain the savings of self-funding **without exposing your company to unlimited risk**.

Role of Third-Party Administrators (TPAs)

While self-funding offers many benefits, it also comes with **administrative responsibilities** that are typically handled by insurance carriers in a fully-insured setup. This is where a **Third-Party Administrator (TPA)** comes in. A TPA is an organization that can handle the day-to-day administration of your self-funded plan on your behalf. This includes processing and adjudicating claims, producing ID cards, managing enrollment, handling customer service for members, compiling required reports, and ensuring compliance with federal regulations[\[12\]](#)[\[13\]](#). Essentially, the TPA becomes your back-office benefits team so that you don't have to build that expertise in-house.

Planstin is an example of an innovative TPA that goes beyond traditional administration[\[14\]](#). Planstin specializes in helping businesses of all sizes implement self-funded benefit solutions that are affordable and easy to manage[\[15\]](#). When you partner with Planstin, you get access to an all-in-one benefits solution: they coordinate healthcare providers and fair-priced networks, arrange the stop-loss insurance (through Graystone) to cap your risk, provide user-friendly enrollment and HRIS technology, and even handle compliance tasks like required plan documents and IRS filings[\[16\]](#)[\[17\]](#). By consolidating these services, Planstin makes self-funding **“seamless”** for employers – even those with as few as 2 employees on the plan[\[18\]](#). In fact, companies using Planstin often realize significant savings (reports of **30% or more** on benefits costs are common) compared to traditional insurance[\[19\]](#). The key is that you're not paying for coverage employees don't use, and every dollar is working directly for your team's benefits.

In summary, **self-funding** your health plan can be a smart strategy to gain control over healthcare spend, customize benefits, and reduce costs. It does require careful planning to manage risk and compliance – but with tools like stop-loss insurance and partners like Planstin to administer the plan, even smaller employers can safely self-insure. By taking advantage of these modern self-funding solutions, your company can provide quality healthcare benefits to employees in a cost-effective way, all while having the flexibility to design a plan that truly fits your workforce[\[9\]](#). It's about **building benefits that suit your business, not the other way around**.

Section 125 Plans (Cafeteria Plans)

Offering health benefits is not just about the insurance itself – it's also important *how* those benefits are offered, especially when it comes to taxes. This is where a **Section 125 Plan**, often called a **Cafeteria Plan** or Premium Only Plan (POP), comes into play. A Section 125 plan is a *formal written plan* that allows employees to pay certain benefit premiums or qualified expenses **with pre-tax dollars**[\[20\]](#). In simpler terms, it's what lets you deduct your employees' health insurance premiums from their paycheck **before taxes are applied**, which saves money for both the employees and the employer.

Without a Section 125 plan in place, any payroll deductions for benefits (like health, dental, or vision premiums) would be taken out after taxes – meaning employees would pay income tax on those dollars, and employers would pay payroll taxes on them. Implementing a Section 125 plan legally enables those deductions to be pre-tax, which is a win-win situation: the employee's taxable income is lower, and the employer's taxable payroll is lower[\[21\]](#).

Why Offer a Section 125 Plan?

Nearly any business can set up a Section 125 plan, and doing so is highly beneficial if you share healthcare premium costs with employees (or offer any plan where employees pay a portion of premiums). Here are the key advantages:

- **Tax Savings for Employers:** When employees contribute to their health premiums pre-tax, you as the employer don't pay FICA payroll taxes on those dollars. This can add up to substantial savings. For example, imagine your employees collectively contribute \$15,000 a month toward their insurance. Without a Section 125 plan, that \$15,000 is part of taxable payroll. With a Section 125 POP, that \$15,000 is exempt from payroll taxes – saving the employer roughly 7.65% (the FICA tax rate) on that amount. In this scenario, the employer would save about **\$1,147 per month**, or **\$13,770 per year**, in payroll taxes. Over time, these savings can significantly offset the costs of running benefit programs. Plus, offering pre-tax benefits can reduce workers' comp premiums (since those are often calculated on taxable payroll) and other payroll-based expenses.
- **Tax Savings for Employees:** Employees also save money because their taxable income is reduced by the amount of their health premium contributions. They end up paying less in federal and state income taxes (and FICA taxes), which increases their **take-home pay**. For instance, an employee paying \$300/month for health insurance could save a few hundred dollars a year in taxes by having that premium deducted pre-tax. A simple example: an employee earning \$6,000/month with a \$300 insurance premium might take home about **\$66 more per month** under a Section 125 plan, which is nearly **\$800 more per year** in net pay. Essentially, their benefits become more affordable.

- **Employee Recruitment and Retention:** Offering a Section 125 plan enhances your benefits package's attractiveness. Employees often take pre-tax premium deductions for granted (many assume it's automatic), but not every small employer offers it. When you do, it's like giving a modest raise – employees have more spendable income than they would if premiums were after-tax[22]. A richer, tax-advantaged benefit package can help **attract and retain talent**, as employees appreciate getting the most value from their compensation.
- **Compliance with Benefits Expectations:** In many cases, setting up a Section 125 plan is not just an “extra perk” but an expectation once you offer health insurance. Employees expect their payroll deductions for health coverage to be handled in the most tax-efficient way. By having a proper Section 125 plan in place, you meet this expectation and avoid unpleasant surprises (like employees discovering they've been paying unnecessary taxes on premiums).

How Section 125 Plans Work

A Section 125 plan must be **established in writing and adopted formally** by the business[23]. It's not an automatic feature of payroll – you need plan documents (sometimes called a plan charter or plan summary) that detail how the plan operates, what benefits are eligible for pre-tax treatment, who is allowed to participate, and so on. Typically, the plan will cover the core insurance premiums (medical, dental, vision, and certain approved supplemental plans) for pre-tax deduction, while excluding things that by law *must* be post-tax (for example, most voluntary accident or hospital indemnity plans, certain life or disability premiums, etc.)[24]. The IRS has strict rules on what can be included in a Section 125 plan – generally traditional health coverage and related benefits qualify, whereas things like tuition reimbursement, mileage, or non-health fringe benefits do not.

Eligibility: Most full-time and part-time employees **can participate** in the Section 125 plan to have their share of premiums taken pre-tax. However, there are important exceptions. Business owners and certain relatives may *not* be eligible, depending on your business structure. For instance, in a sole proprietorship or partnership, the owners (and their immediate family) typically cannot participate. In an S-Corp, any shareholder with >2% ownership (and their family members) are also prohibited from getting pre-tax benefits under Section 125 rules[25]. Additionally, the IRS requires that Section 125 plans do not favor highly compensated employees; there are nondiscrimination tests to ensure that the plan isn't disproportionately benefiting owners or executives at the expense of rank-and-file employees. **Staying within these rules is crucial** – if a Section 125 plan is found to be discriminatory or if an ineligible person receives benefits, the tax advantages could be lost and penalties could apply[26][27].

Plan Operation: Once the plan is set up and communicated to employees, it operates mostly behind the scenes in your payroll. Employees elect to opt in (usually as part of their benefits enrollment) and agree to have their premium contributions deducted before taxes.

After that, each payroll cycle, those deductions are taken out prior to calculating income and payroll taxes. From an employee perspective, their paycheck stubs will show a lower taxable wage and a deduction for their insurance premium, and their net pay is higher than it would be without the Section 125 arrangement. As an employer, you simply remit the premiums as usual (to the insurance carrier or TPA), but you enjoy the payroll tax savings on the back end.

It's important to note that **once an employee elects a Section 125 deduction, changes generally cannot be made until the next plan year** unless there's a qualifying life event. This is due to IRS regulations – pre-tax elections are irrevocable for the year (similar to how 401k contributions or FSA elections work). Employees should be made aware of this, although health plan open enrollment each year gives them a chance to adjust contributions.

Compliance and Getting Help

Because a Section 125 plan is governed by the IRS rules, **documentation and compliance are key**. Here are a few things employers must do to stay compliant:

- **Adopt a Written Plan Document:** As mentioned, you need to have the plan formally in writing and adopted by the company. Many employers overlook this, but **pre-tax payroll deductions are not legally valid without a Section 125 plan document**[\[28\]](#). This document outlines all the plan details and is kept on file (and given to employees as a Summary Plan Description).
- **Operate According to the Plan:** Once in place, you must stick to the rules in your plan document. Deductions should only be for the eligible benefits and participants defined. If you start deducting something not allowed (or for an ineligible person), it jeopardizes the whole plan's tax-favored status[\[29\]](#).
- **Nondiscrimination Testing:** Each year, you should conduct tests (or have them done by a professional) to ensure your Section 125 plan does not discriminate in favor of highly compensated employees or key individuals. This typically involves looking at participation rates and benefits between rank-and-file vs. owners/executives[\[30\]](#)[\[26\]](#). If a test is failed, corrections or adjustments must be made.
- **Employee Notifications:** Employees should be informed about the plan and their choices (usually via an enrollment form or benefits guide). It's also recommended to have them sign an election form that can serve as documentation of their pre-tax election. Good communication helps employees understand the value and any restrictions (like the irrevocability of elections mid-year)[\[31\]](#).
- **Stay Updated:** Tax laws and regulations can change, so it's wise to review your plan documents periodically (at least annually) and amend if needed. For example, if you add a new benefit that could be pre-tax eligible (like an HSA contribution or a new insurance offering), you'd update the plan. Likewise, changes in law (say, new IRS

limits or rules) should be reflected. Regular reviews keep the plan running smoothly[\[32\]](#)[\[33\]](#).

Setting up and managing a Section 125 plan can sound daunting, especially for small business owners who don't have a dedicated HR or compliance department. The good news is that help is available. **Planstin**, as part of its benefits administration services, provides full support for Section 125 plans[\[34\]](#). This includes drafting the required plan documents tailored to your company, ensuring all the i's are dotted and t's crossed with IRS rules, and even assisting with annual compliance tasks. In fact, Planstin offers its Section 125 document service at no extra cost for clients – meaning if you administer benefits through Planstin, they'll take care of setting up your Section 125 plan properly and maintaining it for you[\[34\]](#). This kind of support is invaluable because it removes the guesswork and potential for mistakes (which could lead to tax penalties if not caught[\[27\]](#)).

It's often recommended to consult with a CPA or a benefits professional when establishing your plan[\[35\]](#). By leveraging experts, you ensure that your Section 125 plan is compliant from day one and that you're capturing all possible tax advantages. Given the significant tax savings and the legal requirements, **there's no reason to go it alone**. With a well-run Section 125 plan in place, you'll maximize the value of the benefits you offer – saving money for your business, putting more money in employees' pockets, and strengthening your overall benefits package in the process. It's a straightforward but powerful tool in your employee benefits strategy, and one that virtually any company offering health benefits should utilize.

Applicable Large Employer (ALE) Requirements

If your business is growing, you may find yourself approaching a critical threshold under the Affordable Care Act (ACA). Once you become an **Applicable Large Employer (ALE)**, you have new obligations for providing health coverage to your workers. The ACA defines an ALE as an employer that averaged **50 or more full-time employees (including full-time equivalent employees)** during the previous calendar year^[36]. “Full-time” is specifically defined as anyone working **30 hours or more per week** (or 130 hours in a month) under the ACA’s rules, which is a lower threshold than the traditional 40-hour definition^[37]. Part-time employees still count toward your workforce size on a prorated basis: you calculate the total hours worked by part-time staff in a month and divide by 120 to figure out how many “full-time equivalent” employees those hours represent^[38]. If your combined number of actual full-timers and FTEs meets or exceeds 50 (on average for the year), congratulations – you’re considered an ALE, and ACA’s **employer mandate** applies to you.

What Are an ALE’s Responsibilities?

Being an ALE means you must comply with certain ACA requirements designed to expand access to health insurance. Here are the core responsibilities and rules for Applicable Large Employers:

- **Offer Health Coverage to Full-Time Employees:** Under the ACA’s employer mandate, ALEs must offer **minimum essential coverage (MEC)** – in other words, basic health insurance – to at least **95% of their full-time employees** (and their dependent children)^[39]. Failing to offer coverage to enough full-timers triggers penalties (described below). Essentially, nearly all employees working 30+ hours weekly should be given the opportunity to enroll in your company’s health plan.
- **Ensure the Coverage Is Affordable and Provides Minimum Value:** It’s not enough just to offer any plan – the plan must meet certain standards. To avoid penalties, the coverage you offer needs to be **affordable** (costing the employee no more than a set percentage of their income for the employee-only premium) and **meet minimum value**, meaning the plan is designed to pay at least 60% of total healthcare expenses for a standard population^{[39][40]}. In practical terms, a plan that has very limited benefits or extremely high deductibles might fail these tests. Most typical employer plans or **minimum value plans (MVP)** will meet the 60% actuarial value threshold. Affordability is measured each year (for example, in 2024 a plan was affordable if the employee’s share of single coverage was no more than 9.12% of their household income; for 2025 it’s 8.39%, and around 9.96% for 2026) – the IRS provides safe harbors since employers often use an employee’s W-2 wages or the federal poverty level to gauge this^[41].
- **Report Coverage to the IRS and Employees:** ALEs have annual **reporting requirements**. You must file **IRS Forms 1094-C and 1095-C** each year detailing the health coverage offered (or not offered) to each full-time employee^[42]. Form 1095-C (one per full-time employee) is also provided to employees (similar to a W-2, but

for health coverage) and tells the IRS which months an employee was covered under your plan. This reporting is typically done at the beginning of the year for the previous calendar year's coverage. It's the mechanism that enforces the employer mandate and allows the IRS to see if any penalties should apply (for instance, if an employee went to a marketplace exchange and received a subsidy because you didn't offer qualifying coverage).

Failure to meet these ALE requirements can lead to **significant tax penalties**. The ACA's employer mandate penalty has two tiers, often called **4980H(a)** and **4980H(b)** after the tax code sections:

- **Penalty A – Not Offering Coverage:** If you **do not offer MEC coverage to at least 95% of full-time employees**, and at least one full-time employee obtains a subsidized policy on the Health Insurance Marketplace, you'll owe this penalty. The fine is assessed annually and is calculated as \$2,000 (indexed each year) *per full-time employee*, minus the first 30 employees. For perspective, in 2026 this penalty is about **\$3,340 per full-time employee** beyond the first 30^[43]. So a company with 60 full-time employees that offered no coverage could face a yearly Penalty A on 30 employees (60 minus 30) for a total of about \$100,200. This penalty is often referred to as the "Sledgehammer" because it hits if you fail the basic offer requirement altogether.
- **Penalty B – Offering Coverage That Is Unaffordable or Low Value:** If you do offer coverage but the plan **either isn't affordable or doesn't meet minimum value**, you could be liable for this penalty *for each full-time employee who ends up getting a subsidy on an exchange*. The annual Penalty B is \$3,000 (indexed) per such employee, capped at a maximum equal to the Penalty A amount if that were to apply. For example, in 2025 this penalty is roughly **\$5,010 per affected employee**^[44]. This is sometimes called the "Tackhammer" penalty – it's more targeted. Importantly, Penalty B only applies if an employee actually goes to the marketplace and receives a premium tax credit. If your coverage is a bit pricey or skimpy but all your employees either stick with it or waive coverage without getting subsidized elsewhere, you might technically violate ACA standards but not trigger Penalty B. However, that's a risky gamble, and not a strategy to rely on. The safer approach is to ensure your plan meets the ACA's affordability and value criteria.

To illustrate the potential impact of non-compliance: an ALE that fails to offer any coverage faces Penalty A – roughly **\$3,340 per full-time employee (beyond the first 30)** annually. Meanwhile, an ALE that offers coverage which isn't affordable or lacks minimum value could incur Penalty B – about **\$5,010 per year for each employee** who obtains subsidized marketplace insurance. These figures update annually for inflation, but they underscore that penalties can add up quickly if you fall short of ACA requirements. In many cases, Penalty A can far exceed the cost of simply offering a basic health plan, so it's generally in an employer's financial interest to comply rather than pay the fines^{[43][44]}.

Beyond the mandate and penalties, ALEs also need to adhere to other ACA rules that apply to group health plans – for example, covering adult children to age 26, no pre-existing condition exclusions, providing certain preventive services at no cost, and limits on waiting periods. However, these are standard in most plans and typically managed by your insurance provider or TPA.

Staying Compliant (How Planstin Can Help)

Navigating the ALE requirements can be challenging, especially for first-timers who just crossed the 50-employee threshold. Compliance involves not only offering the right kind of health plan, but also handling paperwork and deadlines (like IRS filings in the first quarter of each year). This is where partnering with a knowledgeable benefits administrator becomes extremely valuable.

Planstin offers comprehensive support to ensure ALEs remain compliant with the ACA. First and foremost, Planstin can administer health plans that satisfy the ACA's standards. They provide plan options that constitute **Minimum Essential Coverage** and also options that meet the **Minimum Value** threshold^[45]. For instance, Planstin's **Preventive (MEC) plans** cover the basic essential health benefits required by the ACA, which can fulfill the mandate to offer coverage at a very low cost per employee^[46]. These MEC plans can be a solution for employers looking to **avoid Penalty A** by covering all full-timers at minimal expense – some employers choose this strategy to meet the letter of the law and avoid the steep non-offering fine^{[43][46]}. However, MEC alone doesn't meet the 60% minimum value rule; recognizing this, Planstin also has more robust **MVP plans** available^[45]. An MVP (Minimum Value Plan) is designed to cover at least 60% of expected costs (for example, a plan with a reasonable deductible and coinsurance might qualify). By offering an affordable MVP plan, an ALE can avoid **Penalty B** as well, because employees won't have a need (or eligibility) to seek subsidized coverage elsewhere.

In addition to the plan design, Planstin's **compliance services** have you covered on the administrative side. They assist with preparing and filing the required IRS forms (1094-C/1095-C) on your behalf^[17], ensuring that documentation is done correctly and on time. Planstin keeps up with the annual changes in affordability percentages, penalty amounts, and coverage mandates – so you don't have to become an ACA expert overnight. They'll alert you to any adjustments needed in contributions or plan structure each year to remain within guidelines.

Moreover, for companies hovering around the threshold, Planstin can help determine if you are an ALE and when you need to start complying. They provide guidance on measuring your workforce (including the tricky full-time equivalent calculations and handling of variable-hour employees). If you have a complex setup with multiple related companies, they can advise on **controlled group** rules that might combine employee counts (making you an ALE sooner than you thought). Essentially, Planstin acts as a partner to **“worry about the rules, so you don't have to”**^[47], which is especially helpful for business owners who already have plenty of other aspects of the company to manage.

To sum up, once you reach 50+ employees, paying attention to ACA requirements is a must. The good news is that compliance is very achievable and need not break the bank. By offering the right kind of coverage – even something basic like a MEC plan – you can dodge the harshest penalties[\[46\]](#). And by partnering with a benefits expert like Planstin, you can confidently handle the **offer, affordability, and reporting** aspects of the law with minimal hassle. Planstin administers plans that meet ACA standards and provides **complimentary compliance support**, from drafting the required plan documents to preparing IRS reports[\[17\]](#)[\[45\]](#). With their help, you can focus on running your business, knowing that your employee benefits program is both competitive for your workforce and compliant with federal law. In an environment of ever-evolving healthcare regulations, having that peace of mind (and avoiding costly penalties) is invaluable for any Applicable Large Employer.

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