THE J. P. FARLEY INDEX MAG | JULY 2026

J.P.F.I

HEALTH INSURANCE AS A BUYING CO-OP

The new era of shared plan responsibility

A 5-YEAR PLAN FOR YOUR PLAN

Long-term thinking for real savings, sustainable benefits, and lasting results.

Contents

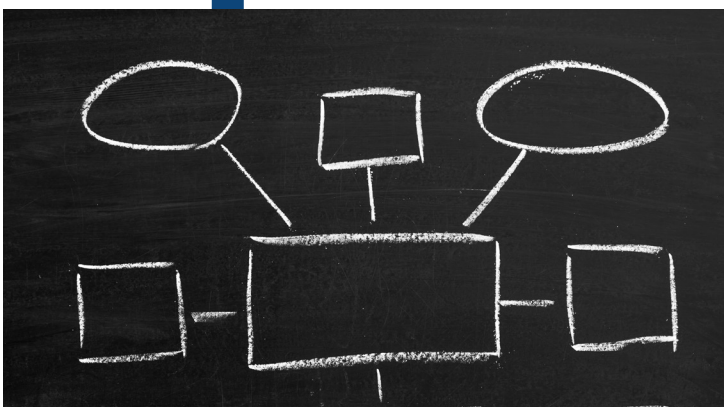
04. Health Insurance As A Buying Co-Op: The New Era Of Shared Plan Responsibility.

08. The CFO's Healthcare Plan Review - Practical Guide

12. **INTERVIEW:** How Nurse Navigators Strengthen Self-Funded Plans- with Casey Billington

16. The $32.6B Ad Budget Hiding In Your Renewal

20. A 5-Year Plan For Your Plan



What's Your Plan?

CEO | J.P.FARLEY

It's common for people to see a renewal coming up and think, ***"Okay, what should we tweak before January?"***

Honestly, that's just not a big enough question. The real question is: ***what kind of health plan do we want to have five years from now?***

That's where this issue starts for me.

A self-funded health plan was never supposed to be some experiment you try for a year and then forget about. For a while, the "discount coupon" pitch was everywhere: switch your plan, save money in year one, worry about the rest later.

But the best-run companies always knew better. They treated self-funding as a real strategy: planned the transition, educated their people, managed the plan year after year, and always played the long game.

In 2026, the old discount game came to an end. With stop-loss pressure, rising claims, unpredictable hospital pricing, and more costs landing on employees, employers have to think differently.

So my take is this: the future belongs to the companies that quit looking for a one-year escape route and start laying the foundation for the next five years.

And this issue of J.P.F.I. Magazine is dedicated to playing the long game.

Jim Farley

Health Insurance As A BUYING CO-OP:

The New Era Of Shared Plan Responsibility

In the old healthcare market, employers could sometimes survive the kind of unmanaged healthcare plan by shopping harder, negotiating harder, or moving to whoever offered the better renewal. That era is ending.
With healthcare prices rising the way they are, no discount, carrier switch, or negotiation can protect a plan if employees are buying care blindly.

For a long time, there was a well-worn script that played out every year for employer health plans.

Here's how it usually went: the employer would get their renewal notice, see the price hike, and immediately call their benefits broker. The broker would then "shop the market," gathering up census data, requesting quotes from every carrier, and coming back with a neat spreadsheet of options.
Maybe the group would move to a new fully insured carrier, or switch to a self-funded arrangement, or just use the threat of jumping ship to negotiate a slightly better deal from the incumbent. Sometimes, the plan design would shift, or the stop-loss carrier would change. Sometimes, nothing much changed at all.

For years, this was considered strategy. And, to be fair, sometimes it actually worked.

Back then, the market had more carriers. There were stop-loss options. **There was always a company willing to offer a "first-year deal" that looked great on paper, just to win your business.** They could come in a couple points below the renewal, pick up your group, and make up the margin in the years that followed. That was the game, and it felt like employers were playing to win.

But that game was never real cost control. It was market shopping. It was moving the same unmanaged behavior from one spreadsheet to another and hoping the next carrier, network, or stop-loss contract would absorb the problem better than the last one.

How the Buying Co-Op Works

When your health plan is experience-rated, and especially when it's self-funded, it's not "insurance" in the way most people think about it.

It's more like a buying cooperative.

The company and its employees are financially tied together by the plan.
Your claims affect the cost for your coworkers; their claims affect yours. **The behavior of everyone in the building has a direct impact on what happens next year.**

This is not about blame or morality. It's just math. **If one person spends plan money unnecessarily, everyone eventually pays for it.** If the group continues to use the most expensive hospital-owned sites for care - even when there are better alternatives - that cost becomes part of the renewal.

If employees rush to use their deductible at the end of the year for care that isn't truly needed, that utilization gets baked into the next year's price. If a physician keeps referring everything inside the most expensive health system, that bill ends up back on the employer's desk.

The Employee's Choice Has to Be Real

A buying co-op only works if employees understand that they have a real choice. The choice is not "use care" versus "don't use care." That is the wrong message. People should get the care they need. The real choice is between unmanaged care and managed purchasing.

Employers need to be plain about this. Say,

"We plan to be in business next year. We want you here next year. We want your family protected next year. But how we all use the plan today shapes what will happen to it tomorrow."

That's the beginning of the real conversation. Employees already know healthcare costs are going up.

West Health-Gallup found that one in three U.S. adults - more than 82 million people - made daily life trade-offs last year to pay for healthcare.

Nearly half of U.S. adults worry they won't be able to afford necessary care in 2026, the highest level of concern since tracking began.

So the employer's message cannot be abstract. It must be practical:

"If we do nothing, costs will rise - for the company and for you. That could mean higher payroll deductions, higher deductibles, or fewer choices in the future. But if we manage the plan together, we can use nurse navigation, choose better sites of care, avoid unnecessary hospital pricing, ask smarter questions before major care, and use preferred pathways. In many cases, the plan will reduce or even waive your out-of-pocket costs for making the best choice."

That's the real choice: manage the plan together now, or all pay more later. That's how the buying co-op becomes real.

The buying co-op gives employers and employees a real choice.

You can let the industry teach your people how to buy care - following hospital logos, drug ads, referral patterns, and the path of least resistance. Or you can **teach them how to buy care** inside your plan.

Hospital Branding Is the Real Competition

For the buying co-op to succeed, employers must realize who they're really up against. It's not just healthcare inflation. It's hospital branding. Hospital systems market relentlessly - stadium sponsorships, community events, airport banners, digital ads, TV commercials, and referral networks.

They build emotional familiarity: they delivered your child, treated your parent, operated on your spouse.

Their name feels safe.

This branding has real impact. A recent National Bureau of Economic Research working paper found that hospital advertising increases patient volume and spending.

Just a 10% increase in regional hospital advertising was linked to nine more hospital admissions per 100,000 beneficiaries and over $3 million in extra Medicare spending each year.

That's the healthcare marketplace your employees are navigating. When someone chooses the expensive hospital system, it may not be because they compared quality, price, or convenience. It may be because the brand got there first.

If an employer wants people to use high-quality, lower-cost options, that message cannot be buried in benefit booklets. It must be repeated, explained, made easy, and connected to employees' own wallets.

Discount From What?

Employers and employees need to learn not to be distracted by "discounts." A network might offer a 20% or 30% discount, but the real question is: "Discount from what?"

A 30% discount off an inflated charge is still a bad deal. A 10% discount off a fair price is better.

Let's say Hospital A charges $10,000 and gives a 30% discount - the plan pays $7,000. But Facility B charges $4,000 and offers a 10% discount - the plan pays $3,600. The bigger discount isn't always the better deal; the lower net cost is.

This is why the buying co-op cannot be based on network logos or discount percentages. It must be built on actual purchasing decisions. RAND's hospital price transparency study found that, on average, employers and private insurers paid 254% of what Medicare would pay for the same hospital services in 2022.

Outpatient hospital services averaged 289% of Medicare rates, while ambulatory surgery centers averaged 170%. Commercial insurance paid 281% of average sales price for hospital-administered drugs, compared to 106% for Medicare.

This is not just a fine print detail - it's core to the buying lesson. Employees need to know that the same service can carry dramatically different prices based on location, and that "in network" does not always mean "best value."

Hospital-owned outpatient departments may cost more than independent sites. The plan may have preferred pathways for imaging, labs, infusions, surgery, or specialty drugs. Employees need this information before appointments are scheduled.

A Buying Co-Op Needs a Guide

A buying co-op will not work if employees are left to figure things out alone. Telling people to "be smarter" is not a plan, it's a wish. The co-op needs a guide, and that's where nurse navigation comes in.

The nurse navigator cannot be an afterthought buried in the benefits packet. The navigator must be the first call before major healthcare decisions: before imaging, infusion, elective surgery, specialty drugs, or defaulting to a hospital-owned outpatient system. The goal is not to deny care, but to help employees get the right care, in the right setting, at the right price, with less confusion.

If you want the buying co-op to work, **the navigator has to be part of the company's culture.** Employees should know who the navigator is, how to reach them, what the process is, and why it matters. They also need to see the benefit to themselves: if using the preferred pathway means a lower deductible or copay, that is a real incentive.

The plan's wallet and the employee's wallet need to be aligned.

The real sign that the buying co-op is working will not come from the first companywide email—it will come from the first employee story. For example, an employee needs an MRI, their doctor refers them to the hospital, but they remember to call the nurse navigator first. They are guided to a high-quality alternative, save money, and have a good experience. Then they tell a coworker about it.

That is watercooler proof. One real story does more to change behavior than a dozen emails. But this takes time. It is not a one-and-done message at open enrollment; it is a process built on repetition, examples, incentives, and trust.

The buying co-op has to be part of a five-year plan: start with education and transition, move to habit-building, then measurement and adjustment, and finally, build culture and discipline. This is about changing how people buy healthcare, not just changing a health plan.

What Employers Can Do Next

First, call the plan what it is - a shared buying system, not just insurance. Tell employees: "This plan is a buying co-op. The company funds it. You use it. Your coworkers use it. The way all of us use it affects what all of us pay."

Second, explain the consequence of doing nothing, without scare tactics. Be honest: "If we do not manage this plan differently, costs will rise. That means the company pays more and employees pay more - whether that's higher payroll deductions, higher deductibles, or more out-of-pocket exposure."

Third, give employees a better path. Tell them: "Before major care, call the nurse navigator. Before imaging, surgery, infusion, or specialty drugs - call. We're not asking you to skip care. We're helping you buy it wisely."

Fourth, make the smarter financial choice for employees. If the plan wants people to use preferred sites, offer deductible waivers, lower copays, or compliance incentives. Employees should be able to say, "This helped the plan and it helped me."

Fifth, include spouses and family members who actually make healthcare decisions. The person attending open enrollment is not always the one scheduling appointments. Use evening webinars, short videos, text reminders, or simple guides to get the word out to the whole household.

Sixth, drop the insurance jargon. Employees do not need a lecture on actuarial trend, they need clear examples: "An MRI at one facility may cost twice as much as another. A hospital outpatient department may cost more than an independent site. A bigger network discount does not always mean a better deal. Call before you schedule."

The CFO's Healthcare Plan Review - ***Practical Guide***

Mercer's 2026 CFO survey found that 1/3 of CFOs now rank health benefit cost as a top-three operating expense concern, up from 19% in 2024. CFOs also reported that health cost growth is affecting wage growth, other benefits, and even the prices of products and services. This shift means the health plan is now part of your overall business strategy. Or, at least, it should be.

1. YOU ONLY HAVE TO REVIEW 15%. At first glance, reviewing a health plan can look like an unreasonable amount of work. Even when the reports are available, the data can feel too large, too technical, and too scattered to turn into a clean financial decision.

But CFO does not need to start by reviewing every employee, every claim, every diagnosis, and every line of the plan. **Healthcare spend is not evenly distributed across the workforce.** In most plans, a small number of members drive the majority of the cost.

1% of members can drive roughly 30% of plan spend.
5% of members can drive roughly 55–60% of plan spend.
15% of members can drive roughly 85% of plan spend.

A one-time claim can impact the plan, but there's often little to manage afterward. **Recurring claims, on the other hand, may need clinical review, nurse navigation, pharmacy planning, site-of-care review, or a different provider approach.**

2. TOP 10 CLAIMS. After you defined the top claimants, it's time to review the top claims - ranking them from highest to lowest. For each high-cost claimant, first ask: What is causing these high costs?

Next, sort the claims into two groups.

The first category is recurring. These are the people who were expensive last year and are expensive again this year. They may have cancer. They may have a serious cardiopulmonary condition. They may have diabetes, COPD, autoimmune disease, or another chronic condition requiring recurring care, recurring drugs, and recurring hospital interaction.

The second category is non-recurring. These may be one-time events: a major accident, a heart attack, a neonatal claim, or an unexpected surgery. These claims may be expensive, but they may not repeat.

JPFARLEY.COM/BLOG

Check the latest episode of the J.P.FARLEY INDEX Show with Casey Billington, Chief Clinical Officer and Co-Founder of Concierge Nurse Navigators.

Learn the role of a nurse as both an employee advocate and a plan-management tool, especially for serious diagnoses, high-cost procedures, confusing bills, and moments when HR should not be expected to carry clinical decisions alone.

After the top 10, look at the top 50. Again, separate recurring from non-recurring. Then ask the next question: is the money going mostly to hospitals, drugs, or both?

3. THE HOSPITAL PATTERN. Once the CFO sees the top claimants, the next question is whether the same facilities, physicians, or care settings keep appearing.

- Is the same **hospital** showing up again and again?
- Is the same **physician** connected to multiple expensive treatment paths?
- Are certain **drugs** being administered in a hospital outpatient department when another site of care may be clinically appropriate?

And remember - your goal is not about cutting benefits. It's about making smarter purchasing decisions.

If a patient can receive **the same clinically appropriate infusion in a lower-cost setting,** the employer should at least know that option exists. The plan may preserve the quality of care, reduce waste, and protect the employee from being automatically drawn into the most expensive version of the healthcare system.

4. BRING IN CLINICAL JUDGEMENT. CFOs don't need to become medical experts. Instead, the CFO should spot financial patterns and bring in experts who can explain the clinical side.

A small group - such as the CFO, CEO, and HR leaders - should review de-identified data. This process should be focused, private, and well-organized.

Then the employer should bring in the advisor, consultant, or broker and ask direct questions.

- What can be done about these claims?
- What is recurring?
- What is preventable?
- What is manageable?
- Where is the site-of-care opportunity?
- Where is the pharmacy opportunity?
- Where is the employee-navigation opportunity?

When needed (and it IS needed at this stage), bring in **clinical experts.** A nurse, physician consultant, or nurse navigator can spot patterns, explain treatment options, identify where support is needed, and help employees understand their choices before fear leads them to costly decisions.

A good nurse navigator is a way to protect employees. The cost savings come from better guidance leading to better choices.

Need a more detailed checklist?
Join the webinar
"The Flat Renewal Checklist For Self-Funded Healthcare Plans."
by James Farley

JPFARLEY.COM/EVENTS

5. BRING EMPLOYEES INTO THE WHY. A CFO's health plan review should never happen behind closed doors. It's essential for employees to know early that this isn't about taking away benefits, it's about making the company's health plan more affordable, usable, and sustainable for everyone.

When employees see that the goal is lower contributions, smaller deductibles, and better support (i.e., more money left at the end of the month), any coming changes feel less like a loss and more like a strategic upgrade.

Bottom line: you can't force smarter healthcare choices. **Show employees why it matters, what's in it for them,** before asking them to change.to be transparent: "We're doing this to protect our plan, eliminate waste, control unnecessary spending, and ultimately keep more of your hard-earned money in your pocket."

6. THE 150-DAY DISCIPLINE. Don't wait for renewal season to start talking. Start the process four to six months ahead - proactive beats reactive every time.

At the six-month mark, CFOs should insist on a thorough claims review. Rank your data from top to bottom. Identify the top 10 claimants, then expand to the top 50. Separate recurring from one-off claims. Break out hospital costs from pharmacy spend. Pay attention to patterns - repeated facilities, physicians, drugs, sites of care, and recurring conditions.

Review disease management and navigation options. Specialty pharmacy costs up? Re-examine your drug strategy. Employees having trouble navigating the system? Time to consider nurse navigation.

By renewal time, you should have a clear picture of what's coming, and why.

What To Do Now

Ensure you have accurate, detailed claims data and follow all privacy guidelines.

Rank claims from highest to lowest; analyze the top 10, then the top 50.

Separate high-cost claims into recurring vs. one-time incidents. Prioritize ongoing conditions over isolated events.

Break out hospital costs from pharmacy costs for targeted review.

Identify patterns: repeat hospitals, physicians, treatment settings, drugs, or conditions. Involve key decision-makers - CEO, HR, advisor, and clinical experts. Keep the group small for efficiency.

Communicate findings with employees transparently, focusing on support, not blame.

Implement early interventions before renewal: nurse navigation, employee education, ongoing claims review, and clinical consultations.

Monitor the top 10% of claims continuously throughout the year, not just at renewal.

Still humans at J.P.Farley

Machines are built to follow scripts. But life doesn't always stick to the script. When a real issue aris-es, an automated system can only lead you to a pro-grammed dead end.

We know what's on the line when it comes to your healthcare.

That's why J.P.Farley doesn't rely on bots.

Your plan is managed by real experts who are accessible during the working hours, and they listen, adapt, and truly understand your situation.

440.250.43.00

jpfarley.com

How Nurse Navigators Strengthen Self-Funded Plans

When infusions can be billed at 700% over what they should be, it does not matter whether your hospital discount is 20% or 22%. The real savings come from helping the employee get to the right site of care before the claim becomes a financial disaster.
Last week, we sat down with **Casey Billington, Chief Clinical Officer and Co-founder of Concierge Nurse Navigators,** to talk about what happens when employees try to use their health plan in the middle of a medical crisis, and how nurse navigators protect both employers and employees.

The "Hospital Funnel" Trap

There is a difference between having a health plan and being able to use it when something serious happens.

For a CEO, it affects the trust employees have in the company. And for the employee, it can affect something much more personal: whether they feel abandoned at one of the most frightening moments of their life.

I do not say that dramatically. I say it because we see it.

A person receives a diagnosis. A spouse starts calling providers. A hospital asks for money upfront. A claim is confusing. A prescription requires approval. A bill arrives that may or may not be correct. The employee may technically have coverage, but in that moment, coverage alone does not answer the question they are really asking:

What do I do now?

That is why I wanted to have this conversation with Casey Billington, Chief Clinical Officer and Co-Founder of Concierge Nurse Navigators.

Casey and her team work directly with members when the healthcare system becomes too complicated. They help people move through the healthcare system with a person beside them

"When someone hears a major diagnosis, their brain shuts off, They need to know who to call."
- Casey Billington

> **“A colonoscopy is pretty much a colonoscopy, and you can pay $6,000 for it or you can pay $1,500.”**

HR Should Not Have to Carry This Alone

HR is often asked to handle problems that are clinical, emotional, administrative, and financial all at the same time.

An employee facing cancer, a high-risk pregnancy, a mental health crisis, a major surgery, a specialty drug issue, or a confusing hospital bill is not simply asking, “What is my deductible?”

They are asking whether they are safe. Whether they are making the right decision. Whether they are about to be financially harmed. Whether they can trust what the hospital told them. Whether they should get another opinion. Whether they can wait. Whether they should be scared.

Casey made the point that **benefits teams may understand the plan, but they are usually not medical.** They are not expected to understand every clinical pathway or every nuance of a serious diagnosis.

A nurse navigator gives employees **a different kind of access point.** Someone clinical. Someone who can explain. Someone who can slow the situation down. Someone who can help the member ask better questions before the wrong decision becomes expensive or irreversible.

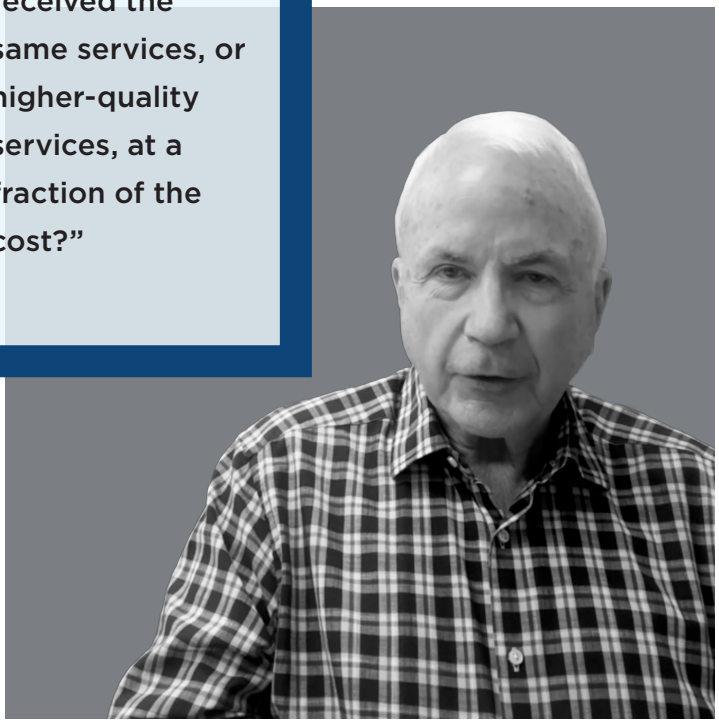
Casey said that if members leave an open enrollment meeting with nothing else, they should at least leave with the nurse’s phone number.

That is a very practical standard for employers - whether the employee knows who to call when something goes wrong.

Besides, a major diagnosis is rarely a single claim. It can involve imaging, surgery, pathology, chemotherapy, infusions, specialty medications, follow-up testing, second opinions, facility charges, and pharmacy costs. If no one is looking at the full picture, the plan may be overpaying in several places at once.

The employer may not see that clearly until renewal. By then, the money has already been spent. Renewal is not the best time to discover that the plan had no strategy for serious claims.

> **“Could we have received the same services, or higher-quality services, at a fraction of the cost?”**



Primary Care Is Still One of the Most Practical Cost Strategies

When an employee has a doctor they can reach, a doctor who knows them, who can answer questions before the employee runs to urgent care or the emergency room, the entire pattern of care can change.

Casey described the value of being able to text a doctor who knows the patient, knows the family, and knows what that person looks like when healthy.

Her conclusion was clear:

"Having that relationship with your doctor is a game changer."

I agree with that.

The traditional system has made that relationship harder. Too often, primary care has become rushed, fragmented, and transactional. Direct primary care can help restore some of the relationship that employees need in order to use healthcare more wisely.

But even then, engagement matters.

A benefit that employees do not use has limited value. A program that sounds good but never becomes part of employee behavior is just another line item.

That is why nurse navigation and primary care can work well together. The nurse can help employees understand why primary care matters, how to use it, and when to call before the situation becomes more serious.

Employees should know who to contact before making major healthcare decisions. That's the true value of nurse navigation: a trusted contact before choosing a facility, paying a bill, or agreeing to high-cost services.

And at last, according to Casey, nurse navigator cannot be effective if the rest of the plan does not respond.

The TPA relationship matters. Eligibility, claims, prior authorizations, provider questions, billing questions, and member responsibility all have to be handled quickly and clearly.

Casey described the value of being able to work with a TPA team in real time when a member is standing at a provider's office and something goes wrong. Maybe the provider says they do not take the insurance. Maybe the system is showing something incorrectly. Maybe the front desk does not understand the plan. Maybe the member is about to be sent away.

If the nurse and TPA can solve that issue while the member is still there, the employee may get care that day instead of losing time, losing trust, and bringing the crisis back to HR.

After all, a nurse navigator provides clinical guidance at the most critical moments. For CEOs, this is about protecting the workforce. For CFOs, it's about controlling costs before they become claims. For HR, it's about giving employees support HR can't provide alone.

The TPA sees the claim. The nurse navigator reaches the patient. A strong self-funded plan needs both.

Because when an employee is holding a diagnosis, a referral, and a bill they don't understand, they don't need another brochure. They need someone to call.

> "We're the hub in the wheel that helps pull all the answers and the people with the knowledge together, so that the patient doesn't have to go to each spoke."

How To Think Like A Self-Funded Employer While Still Fully Insured

The fully insured employer is trained - by custom, by brokers, by carriers - not to touch the machinery. “Wait for renewal. You don’t have the data. You don’t control the plan.” And so, they wait. But waiting isn’t strategy. Waiting is surrendering leverage before the negotiation even starts.

This is the pivot point. If your organization is thinking about self-funding, the most important changes don’t begin with a contract - they begin with a mindset. Self-funding doesn’t transform results by itself. A passive employer with a new funding mechanism is still passive. The real transformation starts when employers challenge their own behaviors: how they educate employees, how they steer care, how they surface and solve costly confusion before it becomes another budget line.

Preparation is all about building the muscles - across HR, finance, and leadership - to ask better questions, to intervene earlier, to treat the plan as a tool, not a bill to be paid. Even before switching to self-funding, employers can start this work:

- Track where confusion and costs escalate for employees
- Identify where plan usage is driving surprises
- Build processes for common pain points: specialty drugs, high-cost imaging, unexpected bills
- Engage employees before they become frustrated consumers
- Bring finance into the conversation before the renewal packet lands.

The first step is not a new contract. The first step is refusing to treat the plan as untouchable. Hands-off is not neutral anymore. Hands-off has a cost - in dollars, in morale, in lost opportunity to change the story for your employees.

That’s why we created The Flat Renewal Checklist. It’s not about waiting for perfect data or the next quarter. It’s about starting now - building readiness, building leverage, building habits that will matter long after the contract changes.

If you’re considering self-funding for January 2027, now is the moment to prepare: not to panic, but to act.

Join The Webinar
"THE FLAT RENEWAL CHECKLIST FOR FULLY INSURED AND ASO PLANS"
by James Farley

jpfarley.com/events

Examine your current plan. Find the gaps. Begin the education. Define your goals. Get clear on what you want your next plan to accomplish before you make the leap.

———————————————

Join our webinar for a practical, step-by-step guide to making that transformation real. Every participant will receive a copy of The Flat Renewal Checklist - a tool for employers who are ready to stop waiting and start shaping their own future.

Register at ***jpfarley.com/events.***
Your opportunity to lead begins before the contract ever changes.

NEWS

The $32.6B Ad Budget Hiding In Your Renewal

Twenty years ago, we would sometimes structure stop-loss coverage without covering drug costs because, frankly, they were not the major threat. There was no reason to pay a premium to protect against something that historically was not blowing up the plan. Hospitals and surgeries drove costs; drugs were an afterthought - rarely worth the anxiety or the premium. That era is over.

In 2026, both healthcare experts and benefit managers agree: never before have prescription drugs so thoroughly upended the economics of employer health plans.

Specialty and breakthrough medications, once reserved for the rarest diagnoses, are now prescribed more widely, and their price tags can be staggering, often running into the hundreds of thousands per year for a single patient.

According to the American Society of Health-System Pharmacists, U.S. spending on specialty drugs topped $301 billion in 2024, accounting for more than half of the nation's total drug spending. These medications can be truly life-saving, such as gene therapies that offer hope for previously untreatable diseases.

Yet, not all new drugs offer transformative benefits; many are incremental improvements over older therapies but carry exponentially higher costs.

This new era is challenging both the financial sustainability of health plans and the ethical frameworks around what constitutes value in medicine.

Who Pays For Dancing In The Fields?

Direct-to-consumer pharmaceutical advertising is a uniquely American phenomenon, with the U.S. and New Zealand being the only countries that allow it.

Turn on the TV, and you'll see people dancing in sun-soaked fields, their health crises apparently solved in the time it takes to microwave popcorn. Those ads aren't cheap. **If a drug is being pitched during a major sporting event or prime time show, you can be sure there's serious money (and even more serious profit expectations) behind it.**

Studies in JAMA and Health Affairs have shown that **most newly approved drugs offer little added benefit compared to older treatments, despite sometimes costing 10 or 20 times as much.** The result: patients lobby for \expensive therapies, and prescribers may acquiesce, pushing up health plan costs for everyone without a commensurate rise in value.

US pharma and healthcare advertising reached approx. $32.6 billion in 2025, driven by massive investments in digital channels and record-breaking TV campaigns.

Employers, especially those with smaller or mid-sized workforces, are caught in a bind. A single high-cost claimant can wipe out profit margins or force premium hikes that employees cannot afford.

A medication that costs $75,000 or $100,000 a year may be very defensible when it allows someone to live a productive life. But if that person is on the drug for 30 or 40 years, that is no longer a one-time claim. That is a permanent financial reality inside the plan. While this reflects remarkable medical progress, it poses a massive burden for smaller employers - one or two such claims can consume an entire company's annual profit. The scale of the problem is growing; a 2025 Kaiser Family Foundation survey found that 36% of large employers' cost increases were driven by prescription drug costs, outpacing hospital and chronic disease expenses.

In addition, the cost of GLP-1 drugs for weight loss, now in widespread use, provides a cautionary tale. While these drugs can aid diabetes management and promote weight loss, their long-term impact on population health and plan costs remains uncertain. Many users discontinue the medication, sometimes regaining lost weight, and adherence rates are low. As of 2025, the average monthly cost of GLP-1 therapy in the U.S. ranges from $1,000 to $1,500 -prices that have forced public sector health plan consortia to deplete reserves and impose hefty assessments on members.

Pharma teaches spending

Studies from the American Academy of Family Physicians have shown that independent PCPs are less likely to overprescribe high-cost therapies than those affiliated with hospital systems, which often profit from in-house pharmacies.

Employers can work directly with these doctors, even offering profit-sharing or bonuses for helping manage costs without compromising care. Pharmacist involvement can further support rational prescribing.

However, such approaches require robust monitoring to ensure that cost-saving does not lead to under-treatment. The balance is best achieved with transparent communication and shared goals.

Employees need to see that responsible healthcare choices aren't just for the company's sake: they're for their own future and the futures of everyone they work with.

Despite the complexity and stakes, most employees remain in the dark about how their health plans work and how their choices impact plan viability. Decades of lackluster communication have bred apathy and confusion, even as out-of-pocket costs rise. Yet **organizations that invest in ongoing, transparent communication - framing their plan as a co-op in which everyone has a stake - report greater buy-in and willingness to consider trade-offs. Involving employees in plan design, through committees or surveys, surfaces important priorities and helps define the threshold at which rising costs become unsustainable.**

The core dilemma is both philosophical and financial: how much is a year of life worth, and how should limited resources be allocated?

U.S. employers now spend nearly $30,000 per employee per year on health benefits, according to Mercer's 2025 National Survey. There are no easy answers, but the path forward must balance innovation, access, and financial stewardship. Thoughtful incentives for primary care, rigorous evaluation of new therapies' value, and true employee engagement are essential.

Healthcare spending isn't an instinct—it's a learned behavior. No one is born thinking the shiniest drug or the biggest hospital is always the best. That mindset is carefully crafted. In 2025 alone, pharmaceutical and healthcare companies spent nearly $33 billion shaping what patients recognize, request, and expect their health plans to pay for.

The real question for employers is: what are they investing on the other side? How much time goes into teaching employees to weigh their options, question price tags, understand real clinical value, and actually use the plan's resources? **Without that kind of education, the most expensive choice becomes the default.** Employees ask for the drug they saw on TV, the hospital they drive past every day, or the new procedure that sounds promising, while the health plan just picks up the tab.

If we want employees to make different choices, they need to understand what's at stake. A self-funded health plan is a shared bank account. Every smart decision protects that pool. Unnecessary spending drains it, bringing higher contributions, bigger deductibles, and slower wage growth for everyone.

Pharma spends billions every year influencing demand. We can't expect an annual meeting and a booklet to be enough of an answer.

The prescribing decisions made today will shape the plan for years. Once an employee begins relying on a particular medication, especially a high-cost one, changing that course becomes far more difficult. That is why employers must influence the decision before the prescription becomes an established habit. Better education and clinical oversight may reduce costs in year one, but their real impact is measured over five years, protecting future renewals from recurring claims that might otherwise become permanent fixtures in the plan.

WE INVITE EMPLOYERS AND BROKERS WHO ARE UNCOMPROMISING ABOUT THE IMPACT OF THEIR HEALTHCARE PLANS TO SCHEDULE A STRATEGIC CONVERSATION WITH JAMES FARLEY

You can also reach out to jim.farley@jpfarley.com . Use "Meeting" as your subject line.

A 5-Year Plan For Your Plan

Long-term thinking for real savings, sustainable benefits, and lasting results.

When I started in this business, there were dozens of real choices: insurance giants and regional upstarts all competing for your business.

Now, the market has consolidated. The few carriers left all use the same risk formulas, the same spreadsheets, the same math. The notion that you can "beat the system" by switching carriers every renewal is, frankly, a myth. It's like thinking you'll outplay the casino by picking a different slot machine each year.

Your costs aren't set by the cleverness of your broker or the logo on your insurance card. They're dictated by your population's demographics and... claims experience.

"Self-funding isn't a Band-Aid. It's a new operating system for your health plan, one that gets smarter and more efficient with every cycle."

Probably the first thing to start with would be - stop relying on a 45-minute open enrollment meeting or a hundred-page plan document nobody reads. Employers who win the health insurance game against the big carriers, talk to their employees, not once a year, but all year.

They educate, they nudge, they listen. And over years, not weeks, they change behaviors. Industry data and the experience of large employers show that it takes at least five years of disciplined self-funding to realize meaningful savings - typically 8%-15%/year less than fully insured plans, with potential for more if you actively manage your approach.

The Power Of Compound Change

It isn't glamorous work. You can't flip a switch and expect employees to abandon the hospital where their kids were born just because it's twice as expensive as the surgery center across town.
You can't expect employees to see the health plan as anything but a deduction from their paycheck unless you bring them into the process - show them how their choices impact their experience, how everyone's dollars are tied together. **That takes time, and it takes trust.**

SUBSCRIBE TO JPFI MAGAZINE ONLINE

JPFARLEY.COM/JPFI

J.P. FARLEY
Empowering People. Elevating Benefits.

The first year of a self-funded plan is about transition and data gathering. But the real change comes after year one, when you can analyze claims, spot trends, and act.

Maybe you discover that MRIs at one facility cost double what they do elsewhere. You implement a steerage program, you educate employees, and you see results - not overnight, but as habits shift.

By year three, you have real data on your interventions.

By year five, you've built a culture of smarter health care decisions, and the savings are exponential.

Assign responsibility. A health plan is often your company's second or third largest spend, yet too many organizations leave it without dedicated leadership. I've asked dozens of owners: What else do you spend a million and a half dollars on annually that you don't have a full-time manager for? The answer is always silence.

You wouldn't tolerate that for any other major line item. Why is the health plan different? Assign responsibility to someone beyond HR team. Make it a priority, not an afterthought.

A successful move to self-funding, or a major plan redesign, both require at least 90 days of preparation.

Rushed 30-day transitions may be technically feasible, but they don't set you up for long-term success. Use this time to design the program, communicate with employees, and set expectations. Transparency early on is the foundation for trust and engagement later.

Employee Engagement

Most employees (and their families) don't understand their health plan. The typical open enrollment is a blur of benefit changes, HR announcements, and maybe a new candy

If you want employees to make smarter choices, you must educate them, repeatedly, over time. Use meetings, digital communications, family outreach, and ongoing reminders. Don't just talk to employees - listen to them. Find out what's working, what isn't, and adapt.

EXAMPLE: STEERING TO HIGH-VALUE CARE

Self-funding gives you access to your claims data to use it. Regularly review utilization, identify trends, and adjust your strategies.

Let's say you identify that **a majority of outpatient surgeries are being performed at the local hospital,** at twice the cost of an independent surgical center.

You roll out a communications campaign, adjust copays, and after a year, you see a 30% shift. This is not theoretical. We see it play out with clients who invest in the process and stick with it.

The five-year mindset isn't just for the Fortune 500. It's an approach any employer can adopt to drive better outcomes for their people and their business.

Continuous Improvement Never Ends

Great health plans are never 'set and forget.'

Build feedback loops, review outcomes, and seek employee input. Each improvement builds on the last, delivering exponential gains over five years.

The organizations that thrive are those that invest in **planning, leadership, communication, and continuous improvement.**

So if you're looking at self-funding as a quick fix, or thinking about it as a way to shave a few points off next year's renewal, I'll be blunt: don't bother. But if you're ready to manage it as an operation, to invest in your people and your processes, to learn and adapt for the long term, then you'll find the rewards multiply, year after year.

If you bought a $15,000 machine for every employee, every year, you'd at least make sure they knew how to use it. Why not do the same with your health plan?

YouTube

youtube.com/@jpfarleycorp

Welcome to the J.P.Farley Show hosted by James Farley.

With over 50 years of experience in self-funded healthcare, James has seen what works and what doesn't. Every episode bridges the critical gap between the boardroom and the waiting room. We bring together leaders, plan administrators, and employees to talk openly about what really happens when healthcare meets real life. You'll hear about facing a health crisis, the worry of paying for care, and the ways people help each other every day. These are the stories that remind us why healthcare matters.

jpfarley.com/blog

linkedin.com/in/james-farley-tpa

Clear Thinking on Healthcare Plan Strategy, Cost Control, and Better Plan Performance - ***Delivered To You***

Healthcare plan decisions do not begin and end at renewal. They affect payroll, employee trust, claims behavior, stop-loss outcomes, vendor performance, and the financial stability of the plan itself.

The J.P. Farley Blog gives employers, brokers, and plan leaders clear, actionable perspective on self-funded healthcare strategy, plan administration, cost control, member support, and the decisions that determine whether a plan works in the real world.

Subscribe on the website and Linkedin.

What Is J. P. Farley Expected To Do?

SERVICE

- Dedicated call center
- Multi-audience assistance (member, provider, plan sponsor)
- Multi-channel communication (phone, web portal, mobile app, vendor support, etc.)
- Assist with claim status, benefit questions, prior auth, etc.
- Manage or support patient advocacy efforts
- Manage or facilitate patient navigation services
- Assist in vendor benefit communication and/or referral
- Ongoing account management and coordination with broker/advisor

CLAIMS ADMINISTRATION

- Receive & process claims via proper procedures for all plan types
- Fee schedule management
- Out-of-network management and processing
- Adjudicate claims according to plan document terms
- Issue explanation of benefits (EOB)
- Detect & investigate fraud and abuse.

ELIGIBILITY AND ENROLLMENT

- Eligibility & enrollment record maintenance
- Open enrollment and qualifying events
- Plan ID cards
- Coordination of benefits and COBRA
- Eligibility data management and exchange of the feeds

VENDOR COORDINATION

- Outside vendor coordination & billing
- Outside vendor downloads
- Assistance in applicable plan communication efforts
- Investigate & establish partnerships to enhance member experience & facilitate plan sponsor goals
- Contact management

PHARMACY BENEFIT MANAGEMENT SUPPORT

- Support PBM benefit and eligibility
- Assist with referrals to specialty services

CARE MANAGEMENT SUPPORT

- Support pre-certification and utilization review
- Interface with chronic, high-risk and specialty programs

PLAN DESIGN AND DOCUMENTATION

- Plan document drafting
- Medical benefits schedule (SPDs & SBCs)
- Prescription drug benefits schedule
- Establish and manage defined terms
- Plan exclusions
- Provide education, clarification, and guidance on plan

DATA AND REPORTING

- Ongoing monthly and quarterly reporting
- Ad hoc and custom reporting
- Cost trend and utilization analytics
- Coordination and/or integration of vendor reporting
- Renewal package reporting
- Annual reporting and analysis

STOP-LOSS MANAGEMENT

- Manage policy shooping with qualified carriers
- Negotiate rates
- Stop loss placement and contract review
- Audit policy regularly ensuring all applicable claims qualify
- Monitor individual claimant and aggregate thresholds
- Stop loss claim filing and recording
- Provide education, clarification and guidance on policy
- Plan renewal strategy analysis and support

FINANCIAL MANAGEMENT

- Third-party recovery and subrogation
- Funding and payment of benefits
- Plan funding management
- Reconciliations and reporting

COMPLIANCE

- COBRA continuation
- HIPAA privacy notices and HIPAA data security
- ERISA rules and requirements
- Timely and accurate data delivery of required disclosures
- Assistance with certain plan sponsor / employer compliance requirements

440.250.43.00

jpfarley.com

* The $40 TPA fee covers J.P. Farley's administrative services only.
Additional fees apply for PPO networks, telemedicine, and other third-party vendors.

A Timeline Of Advocacy: 50 Years Of Protecting Your Plan

1979

1979 | Serving the People Behind the Paycheck

The journey began by managing plans for local auto dealers, their unions, and public television stations. This early experience working alongside the manufacturing and working class set a strict, non-negotiable standard: every single dollar matters.

The foundation of the company was built on the reality that a health plan is the financial security of hard-working people who need their paychecks protected.

1985

1985 | Shielding Employers from Medical Overreach

Why should a health plan pay for a seven-day hospital stay when three days is just as medically sound? Recognizing the vast knowledge gap between hospitals and patients, it became clear that employers needed a defense mechanism against localized billing practices and unnecessary medical procedures.

By adopting provider networks and pre-certification early on, the goal was never to be "innovative" for the sake of it, but to ensure that plan dollars were spent on ACTUAL care.

1999

1999 – Mid-2000s | Providing Stability Through Economic Turmoil

As the dot-com crash and the buildup to the real estate crisis caused widespread financial anxiety, employers needed faster, more reliable answers.

To provide stability, operations were completely digitized.

Transitioning to paperless claims wasn't just a tech upgrade; it was a way to ensure that when economic times got tough, clients had immediate, efficient access to their data, giving them a cost-effective operation they could trust while massive carriers pushed the illusion of "50% discounts."

2011 | Fighting for Total Transparency (Even When It Hurt)

Employers and employees deserve to see their claims and eligibility in real-time, plain and simple. Building this transparency wasn't easy; in fact, the initial transition to a real-time platform was a brutal, bumpy road that caused real growing pains.

But the commitment to giving plan participants total visibility meant weathering the storm until the system worked perfectly, ultimately putting control and clarity back into the hands of the people paying for the care.

2011

2017

2022

2026

2030

2017 | Ending the Healthcare "Broken Telephone"

Navigating the healthcare system had become a confusing, frustrating loop between TPAs, brokers, hospitals, and patients.

To relieve this burden on HR teams and employees, the entire service model was reimagined to humanize the experience. By cutting out the disconnect and fostering direct communication, plan participants finally gained a clear, compassionate pathway from their initial doctor's appointment straight through to the final payment.

2022 | Grounding the Process Post-Pandemic

Coming out of a historic period of global uncertainty, employers craved stability more than ever. Operations were heavily fortified inward to ensure that clients had a steadfast, reliable partner they didn't have to worry about. The focus shifted to making plan management effortless for administrators and seamless for employees, offering a predictable, steady anchor in an incredibly unpredictable market.

2026 | Guarding Budgets Against Industry

After witnessing every conceivable right and wrong way to manage a health plan over the last half-century, we condensed that knowledge into practical tools for employers. We introduced the JP Farley Index alongside the Flat Renewal Checklist for both fully insured and self-funded plans. This is a definitive blueprint designed to guide employers away from passive spending and toward active, effective plan management. We don't just hand over this roadmap; it is the exact standard we live by in our daily operations.

Clients who commit to this framework see tangible, positive results for both their corporate bottom line and their workforce. Because true stability does not happen overnight, we align with businesses operating on a five-year vision. For companies planning to be around for the long haul, our mission is to ensure your healthcare plan stops acting as an unpredictable operational expense and starts functioning as a reliable system that genuinely supports your people.

2030 | Keeping Care Human in an Automated World

As AI and automation threaten to turn healthcare into a faceless, mechanized process, the ultimate goal is to fiercely protect the human element.

When an employee is facing a medical crisis, or an employer is trying to balance a tight budget, they deserve to speak to a real person who understands their unique struggles.

The future of the health plan is ensuring that genuine, human compassion never gets replaced by an algorithm.

J.P.Farley Corp
THIRD-PARTY ADMINISTRATOR | SINCE 1979

Phone. 440.250.4300
jim.farley@jpfarley.com
29055 Clemens Rd
Westlake, OH 44145