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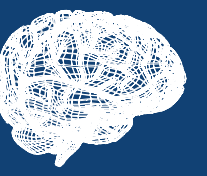
THE FLAT RENEWAL CHECKLIST FOR FULLY INSURED, ASO, AND SELF-FUNDED HEALTHCARE PLANS



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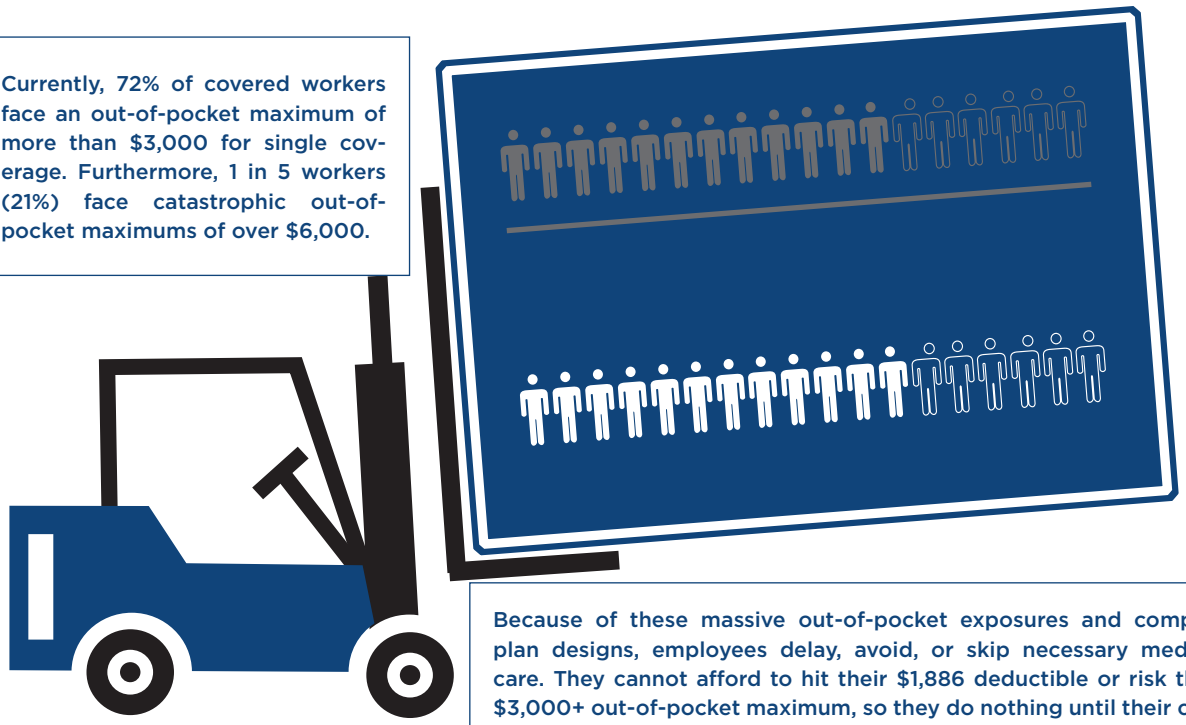
The Numbers Dictating Action: Inside the 2026 Healthcare Market

Currently, 72% of covered workers face an out-of-pocket maximum of more than $3,000 for single coverage. Furthermore, 1 in 5 workers (21%) face catastrophic out-of-pocket maximums of over $6,000.



Because of these massive out-of-pocket exposures and complex plan designs, employees delay, avoid, or skip necessary medical care. They cannot afford to hit their $1,886 deductible or risk their $3,000+ out-of-pocket maximum, so they do nothing until their condition becomes a severe emergency.

- According to the 2026 Howden Global Employee Health Report, **only 57% of employees start treatment within a week of a diagnosis.**
- Of those who delayed care, **36% say the delay actively made their condition worse.**
- The 2026 Sonder State of Employee Health report found that **1 in 3 employees put off medical care in the past year.** While 42% brushed off symptoms as "not serious enough," the other top barriers cited were long wait times, busy schedules, and high out-of-pocket costs.
- Even with employer-sponsored private coverage, **41% of employees still had to pay out-of-pocket to get timely treatment** due to network constraints or high deductibles (Howden, 2026).

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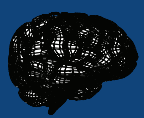
FINANCIAL TRANSACTION
SURROUNDED BY EMOTION.

IN THE SELF-FUNDING WORLD
SINCE 1979

J.P.Farley operates on a fixed-fee structure, without commissions, or revenue tied to claims volume.
We don't make more when your plan spends more.
So the only way we win is by making the plan work better and keeping our clients for years.

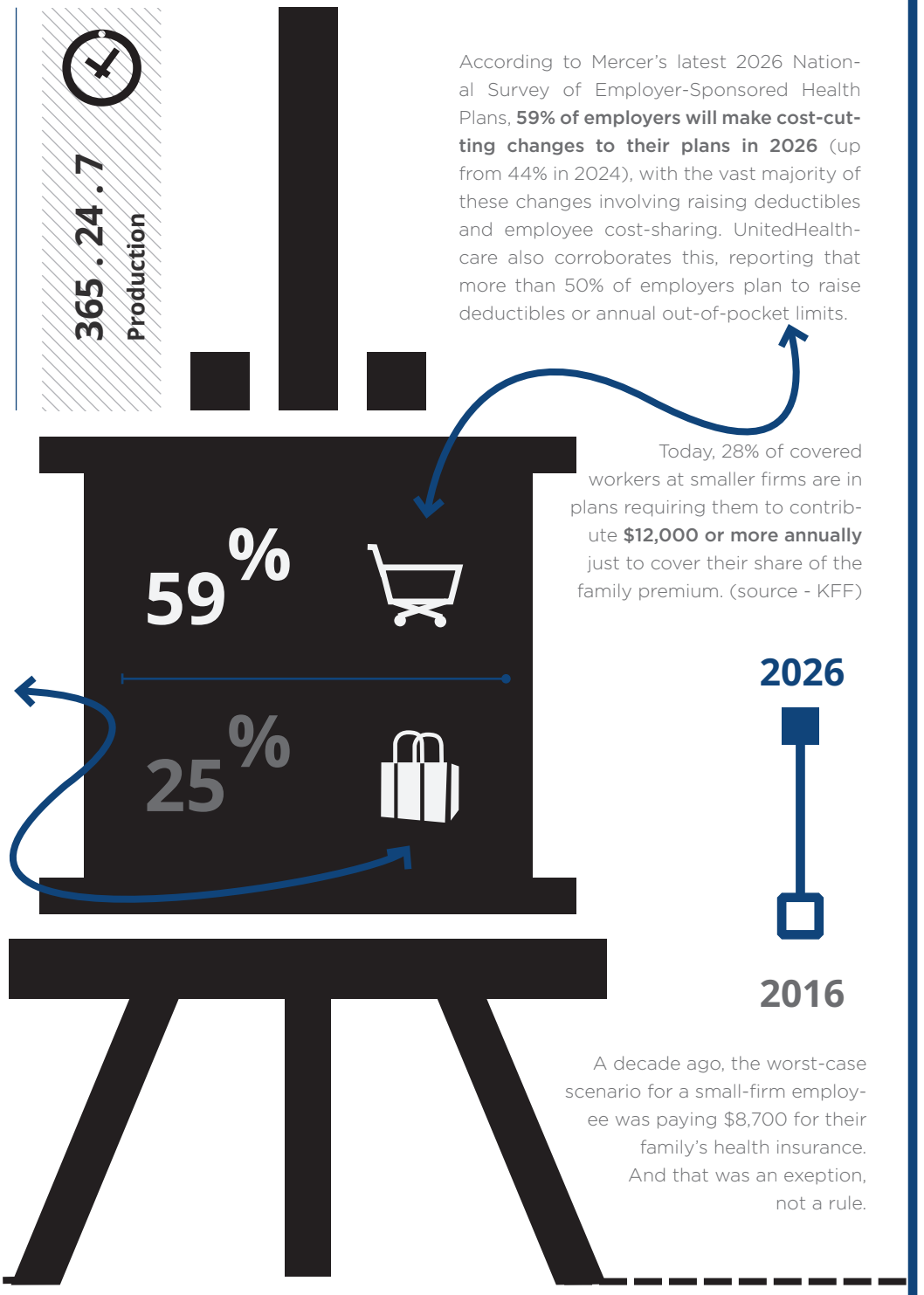


The Flat Renewal Checklist

The siloing of HR and Finance is ending. 58% of organizations now report that the CFO and HR share equal, co-managed responsibility for overall healthcare strategy and plan design.

Given the budget volatility, 42% of CFOs report strong interest in exploring alternative, defined-contribution approaches (like ICHRAs) or self-funded structures that allow them to control their own cash flow rather than paying a fixed premium to a carrier.

Only 1 in 4 CFOs (25%) say their organization was able to absorb recent healthcare cost increases without negative business impacts.
The other 75% were forced to respond with slower wage growth, reduced hiring, or raising prices on their own products and services.



According to Mercer's latest 2026 National Survey of Employer-Sponsored Health Plans, **59% of employers will make cost-cutting changes to their plans in 2026** (up from 44% in 2024), with the vast majority of these changes involving raising deductibles and employee cost-sharing. UnitedHealthcare also corroborates this, reporting that more than 50% of employers plan to raise deductibles or annual out-of-pocket limits.

Today, 28% of covered workers at smaller firms are in plans requiring them to contribute **$12,000 or more annually** just to cover their share of the family premium. (source - KFF)

2026

2016

A decade ago, the worst-case scenario for a small-firm employee was paying $8,700 for their family's health insurance. And that was an exeption, not a rule.

The Flat Renewal Checklist For Fully Insured & ASO Plans

32 disciplines that separate employers who get surprised at renewal from those who do not.
Fully insured employers are not powerless - they are simply operating with less visibility than they deserve. That is not an excuse for passivity. The carriers have the claims data. You have the organization. What you do with your side of that equation determines whether you walk into renewal prepared or whether you walk in hoping.
Every item on it is something a disciplined employer can do right now, without waiting for a carrier's permission or a broker's initiative.

Score it honestly. The gaps you find are your agenda.

Score each item:

0 — Not in place
1 — In progress or inconsistent
2 — Fully in place and functioning

LEADERSHIP ACCOUNTABILITY & PLAN GOVERNANCE

- One internal person is assigned ownership of the healthcare plan.
- Healthcare plan review is scheduled at least quarterly.
- Healthcare plan review is scheduled at least quarterly.
- A written renewal goal exists for the current plan year.
- A documented process exists for escalating recurring plan problems.
- Senior leadership participates in at least one plan review before renewal.
- The person assigned to the healthcare plan is analytical by nature or train- someone who will engage with numbers, patterns, and findings, not just complaints.
- At least one person in the organization understands that healthcare is a financial function, not only an HR function.

EMPLOYEE FEEDBACK & ISSUE TRACKING

- Employee complaints about bills, deductibles, access, or confusion are logged in one place.
- Recurring issues are reviewed at least quarterly.
- The three most common employee plan complaints have been identified.
- A survey, questionnaire, or structured feedback process has been used within the last 12 months.
- Feedback is grouped by issue type, such as billing, access, deductible shock, or claim confusion.

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[WEBINAR] How To Sell Self-Funding As A Five-Year

Position self-funding as a strategic, multi-year solution

- The HR person or benefits contact maintains a written, de-identified summary of what they are hearing about what is going on in the plan.
- A structured list of questions exists for the HR person or benefits contact to use when an employee or family member is dealing with a significant health situation.
- When an employee or covered member is dealing with a high-cost condition such as cancer, a transplant, an infusion drug, or a major surgery, someone in the organization is aware early enough to connect that person with a nurse navigator or advocacy resource before the cost compounds.

COMMITTEE AND OPERATING DISCIPLINE

- A small internal group reviews plan issues on a recurring basis.
- Meeting notes or action items are kept from those reviews.
- One person is assigned to follow up on each major issue identified.
- Open issues are tracked until resolved or closed.
- A list exists of changes the company wants to make before the next renewal.
- The broker or advisor has been asked for additional reporting or carrier information within the last 12 months.
- A person with some medical knowledge - a nurse, a clinically trained advisor, or a similar resource - is involved in the committee review process, or is consulted prior to the senior leadership review.
- The committee separates high-cost claims into two columns: one-time catastrophic events and recurring conditions. They are reviewed as different categories, discussed for different reasons, and planned for with different responses.

EMPLOYEE SUPPORT AND PRE-TRANSITION READINESS

- Employees have access to a nurse, navigator, advocacy line, or similar support resource.
- Employees are told how to access that resource in writing.
- The company has reviewed whether employees are actually using that resource.
- At least one current plan feature has been identified that could be redesigned to reduce avoidable employee friction.
- There is a documented list of information the organization intends to request from the carrier before the next renewal cycle. Know what you need before you need it.
- A written transition-readiness file exists if the company is considering a move toward self-funding.
- At least one plan feature or incentive exists to steer members toward better or lower-cost care decisions.

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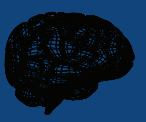
[WEBINAR] How A Bad TPA Can Ruin A Good Self-Funding Plan

NOTE: Look for the Takeaway Pack after the session: **a First 90-Day Checklist and a Broker Scorecard for evaluating TPAs.**



The Flat Renewal Checklist For Self-Funded Plans

Once a plan is self-funded, the first job is to get the claims data, rank it, and identify where the money is actually going. In a 100-life group, the top five people may drive roughly 60% of total spend, and the top 15 may drive roughly 85%. That means flat-renewal discipline starts with claims visibility.

Score it honestly. The gaps you find are your agenda.

Score each item:

0 — Not in place
1 — In progress or inconsistent
2 — Fully in place and functioning

CLAIMS VISIBILITY

- Claims data can be exported into Excel or another sortable format.
- Total annual spend has been ranked from highest claimant to lowest.
- The five highest-cost claimants have been identified.
- The top 15 highest-cost claimants have been identified.
- The percentage of total spend driven by the top 5 claimants has been calculated.
- The percentage of total spend driven by the top 15 claimants has been calculated.
- Large claims are reviewed by condition, procedure, or treatment category.
- One-time catastrophic claims have been separated from recurring claim patterns (accident, broken bone with no ongoing consequences vs. an ongoing condition requiring continued treatment).
- High-volume claims have been reviewed alongside high-cost claims.
- If a disproportionate volume of claims is concentrated with one or two providers, that is a flag worth investigating.

CLAIM-DRIVER REVIEW

- The highest-cost ongoing conditions in the plan have been identified.
- Ongoing high-cost conditions are reviewed separately, including diabetes, heart conditions, cancer, and back or orthopedic conditions.
- Each top claimant has been reviewed for site of care, treatment path, provider quality, and price variation.
- Drug sourcing and drug administration setting have been reviewed for major ongoing conditions.
- High-utilization and high-cost providers have been identified.
- The plan knows which of those providers are employed by hospital systems or other financially integrated organizations.
- Referral and prescribing patterns from those providers have been reviewed for in-system concentration.

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J.P.F.I. NEWSLETTER

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ONGOING CONDITIONS TO MONITOR

1. Diabetes
2. Heart conditions (including pre-condition, multiple heart tests showing progression)
3. Cancer
4. Back condition / orthopedic conditions
5. Infusion drug cases (any condition requiring regular infusion therapy administered in a hospital or outpatient hospital setting)
6. Transplant cases or post-transplant drug regimens
7. Any serious condition where the treating physician is hospital-employed.

- The plan has assessed whether employment-related referral patterns may be increasing cost without improving quality.
- Avoidable or reducible spend categories have been identified.
- Large-claim reviews are scheduled at least quarterly.
- Pre-renewal claim review begins at least 150 days before renewal.
- The plan has evaluated whether prescribing and referral decisions may be influenced by provider-system financial incentives, not just clinical judgment.

INTERVENTION AND EMPLOYEE SUPPORT

- Employees have access to a nurse, navigator, advocacy line, or similar support resource.
- Employees are told how to access that resource in writing.
- Utilization of that support resource is reviewed at least annually.
- A process exists for intervening early in emerging high-cost cases.
- At least one plan feature or incentive exists to steer members toward lower-cost care pathways. Employees act on their own incentives. If using the nurse navigator or choosing a lower-cost site of care saves the employee nothing, most will not do it. The incentive must be real - zero deductible, reduced out-of-pocket, or a similar tangible benefit tied to the desired behavior.
- At least one case example exists showing employee savings or plan savings from guided care.

VENDOR ALIGNMENT AND RENEWAL DISCIPLINE

- TPA compensation is documented in a way the employer can review.
- Stop-loss deductible options have been compared with total expected cost, not just perceived safety.
- A documented review exists of whether low visible fees are being offset elsewhere in the plan.
- A written action plan exists for the next renewal based on claims findings, support usage, and vendor review.
- If the stop-loss carrier has applied a laser or rate adjustment tied to a specific member or condition, the employer has asked for the basis of that adjustment and has not accepted it without review.

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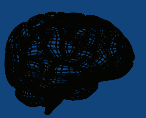
[WEBINAR] The J.P.Farley Paycheck Index: Healthcare Through The Employee's Wallet

Most health plans are discussed in the language of premiums, networks, and logos.
But employees experience them in the language of paychecks. In this webinar, James Farley introduces a more honest framework for evaluating healthcare: the paycheck FORMULA behind the plan.



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

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

Active, Transparent Plan Management

In this business, silence is usually a sign of neglect. True advocacy requires a level of activity and "roll-up-your-sleeves" hard work that most companies simply won't bother with. We look at the details - the "Actively At Work" clauses and the hidden fee structures, because that is where your plan's integrity is either won or lost.

We treat your capital as if it were our own, with a sense of fiduciary duty that is, quite frankly, a rarity today. It takes more effort to be this involved, but at the end of the day, I want to look our clients in the eye and know we did everything in our power to keep their plan sustainable, transparent, and, above all, human.

- Jim Farley | CEO | J.P.Farley | Since 1979

Dedicated Call Center

Our call center is structured to prioritize the people who matter most: your employees and their providers. By routing members and doctors directly to dedicated human representatives, we ensure immediate, queue-free assistance for real problems.

Meanwhile, routine administrative inquiries from high-volume offshore billing companies are intelligently diverted to an AI system, protecting our staff's time so they remain entirely focused on delivering exceptional, hands-on support to your team.

Patient Advocacy, Navigation, and Vendor Referral

We empower your employees with dedicated nurse navigators who provide expert, localized guidance through a complex healthcare system. Instead of relying on guesswork, members receive objective, data-driven recommendations for high-quality, lower-cost care. This highly utilized service not only delivers a vastly superior, stress-free member experience but consistently drives down overall plan costs by steering patients away from overpriced, underperforming facilities.

Ongoing Account Management And Coordination With Broker

We believe in proactive, year-round plan monitoring rather than just showing up at renewal time. By actively analyzing your real-time, self-funded data, we identify emerging trends, track provider network shifts, and monitor funding levels as they happen.

If an issue arises, we communicate immediately with you and your broker, ensuring small anomalies are resolved with a phone call before they ever have the chance to become a crisis.

Plan Design Documentation And Support

The plan document is the legal foundation of your healthcare strategy, dictating exactly how every claim is adjudicated and paid. We draft, maintain, and manage these comprehensive documents, alongside simplified Summary of Benefits schedules, to ensure absolute structural accuracy.

Beyond just drafting the rules, we provide ongoing education to plan sponsors and members so everyone clearly understands how their coverage actually works.

Claims Administration

We meticulously translate your custom plan document into our operating system so that every claim is correctly routed, priced, and adjudicated against the appropriate fee schedules and network rules. Furthermore, we actively combat the industry-wide drain of fraud, waste, and abuse by thoroughly investigating flagged claims, keeping your data entirely transparent so you know exactly where every dollar of your plan is going.

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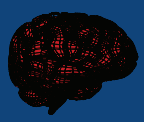


TPA Services

Financial Management

To capitalize on the true value of a self-funded plan, your data and funding must be actively managed all year long. We handle the full financial lifecycle, including funding of benefits, payment releases, reconciliations, and complex third-party subrogation recoveries.

By keeping a close eye on utilization and cost trends, we ensure claims are paid on time and empower you to make data-driven decisions that can yield real savings for both the company and your employees.

Eligibility And Enrollment Management

Flawless eligibility management is critical to a smooth member experience, which is why we automate the process by interfacing directly with your payroll system. We expertly handle open enrollments, qualifying events, COBRA, and ID card issuance on a strict timeline to prevent the rushed errors that disrupt coverage, ensuring your employees are correctly added and supported from day one.

Stop-Loss Management

Stop loss is your self-funded safety net, but it only works if it is meticulously managed against the complex timeline of lagging healthcare claims.
We handle the entire lifecycle of your policy: shopping the market, negotiating contracts, and actively auditing claims to ensure every eligible dollar is filed. By aggressively monitoring claimant thresholds and keeping the contract structure clean, we ensure your policy pays out exactly when you need it most.

Care Management Support

For complex cases and high-cost claimants, coordinated care management can be the difference between a controlled condition and hundreds of thousands of dollars in excess claims.

We seamlessly facilitate pre-certification, utilization review, and specialty high-risk programs, ensuring that external care management vendors interface perfectly with our claims system to deliver timely, effective interventions.

Pharmacy Benefit Management Support

We ensure the pharmacy experience is seamless for your members, starting with an ID card that works flawlessly on day one. When complex exceptions arise—such as the need for specialty medications, infusions, or international sourcing—we provide hands-on guidance to walk employees through the referral process, maximizing plan savings without sacrificing member convenience.

Vendor Coordination

A modern self-funded plan is an ecosystem of networks, PBMs, and specialized point solutions that only succeed when they are perfectly synchronized.

We build and test the critical two-way electronic interfaces required for accurate billing and data exchange, carefully vetting each addition to ensure new programs genuinely enhance the plan rather than crushing it under the weight of uncoordinated administrative bloat.

Compliance

In an era of increasing enforcement and fiduciary liability, we protect your organization by flawlessly executing routine obligations like COBRA, HIPAA, and RxDC reporting. More importantly, we operate on a strict, transparent, flat-fee model with absolutely no hidden commissions or vendor kickbacks, ensuring our guidance is always entirely aligned with your plan's best financial interests.

YouTube

https://www.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.

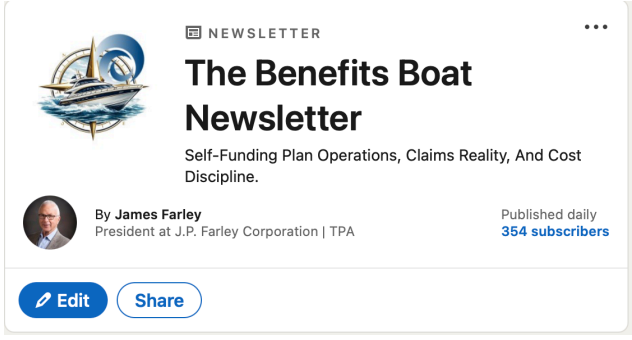
jpfarley.com/blog

Clear thinking on healthcare plan strategy, cost control, and better plan performance - delivered directly 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.

linkedin.com/in/james-farley-tpa/



Join the J.P. Farley Strategy List

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

-J.P. Farley has helped organizations break free from rising costs and one-size-fits-all solutions, using deep industry knowledge to design self-funded plans that deliver lasting savings and better outcomes.

If you're ready to rethink your approach and gain a real competitive edge, now is the time to talk.

JPFARLEY.COM/CONTACT

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

A Timeline Of Advocacy: 50 Years Of Protecting Your Plan

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 | 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 – 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."

1979

1985

1999

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.

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Company Timeline

2011

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

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

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

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.

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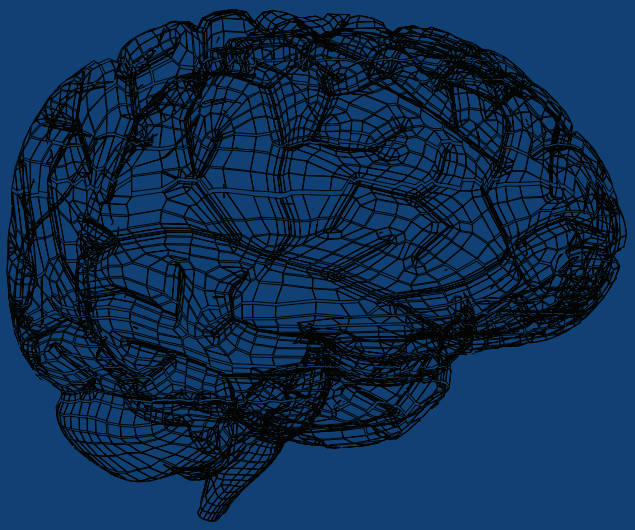

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