

# J.P.F.I.

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The background image features two classical marble statues. In the foreground on the right, a close-up profile of a woman's head with flowing, curly hair. In the background on the left, a seated male figure, likely Odysseus, looking out over a vast blue sea towards distant mountains under a clear sky.

## You're Self-Funded. But Did You Actually Leave Fully Insured?

Like Calypso ("Odyssey"), fully insured keeps employers captive through the illusion of comfort...

## The No-Surprise Act's Surprise: You May NOT Have To Pay Yet.

Deep discussion with No Surprises Act attorney Christine Cooper and veteran ERISA counsel Jack Towarnicky.



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## CEO | J.P.FARLEY

**I have always thought Calypso's greatest power over Odysseus was not love, magic, or the promise of immortality. It was comfort.**

For seven years, Odysseus remained on an island that required very little from him.

And there is an interesting lesson in that. People are quite good at recognizing danger when it looks dangerous. We are much worse at recognizing an arrangement that has stopped serving us when the arrangement remains comfortable.

The insurance business has understood the value of comfort for a long time.



Fully insured healthcare offers employers a very simple bargain: pay the premium and let somebody else take care of the rest. There is nothing wrong with paying for convenience. The mistake begins when we stop calculating what that convenience costs.

**Eventually, many employers do the calculation and move to self-funding. But changing the financing mechanism is easier than changing the habit.**

They naturally want the economics and control of self-funding with the comfort of fully insured, and many assume they can have both by default. After fifty years in this business, I have learned that the market is remarkably fair about such things: you rarely get to take out more than you are willing to put in. The savings, control and better healthcare that self-funding can produce are not free benefits attached to a different funding mechanism. They are the return on accepting responsibility, doing the work, and accepting some of the friction that fully insured was designed to remove. If all of that could be avoided while keeping all of the advantages, there would be very little reason for anyone in America to remain fully insured.

I have watched employers leave fully insured and then carefully reconstruct much of what they left behind: one vendor, one answer, someone else selecting the stop-loss arrangement, someone else controlling the data, someone else deciding what gets paid.

In October issue of the J.P.Farley Paycheck Index we are examining some arrangements the industry has become remarkably comfortable NOT examining - and asking a very simple question: If you are self-funded, did you actually leave fully insured?

Calypso did not need chains. Comfort did the job remarkably well.

*Jim Farley*

# What **FULLY INSURED** *Is Really Selling*

For years, people in the self-funded business have explained fully insured healthcare by describing everything that is wrong with it. The hidden compensation, the lack of useful claims data, the inflated provider charges, the pharmacy spreads, the rebates and the annual increases all deserve scrutiny. But this criticism misses a more useful question: if the fully insured model is so flawed, why does it continue to control so much of the market?

The answer is that insurance companies are not merely selling healthcare financing. They are selling familiarity, simplicity and the transfer of responsibility. They give the employer a recognizable logo, a large provider network, a polished consultant and a reasonably quiet benefits department. Whether they control the underlying cost is a different question. In many cases, the product succeeds precisely because the employer is not required to ask it.

To understand how we arrived here, it helps to go back to the early 1990s. At the time, there were far more insurance companies, far more independent administrators and far more hospitals competing for business. In the Cleveland market alone, there were roughly 30 hospitals. Today, most of that market is concentrated among a few large systems.

The original provider networks offered something quite understandable. A group of suburban hospitals might approach a health plan and offer a six percent discount in exchange for directing employees to their facilities. The hospitals received volume, the employer paid less, and the discount was calculated from prices that still had some relationship to the underlying service.

Then the national networks arrived, and the arithmetic began to change. Large carriers demanded discounts that hospitals said they could not afford. The solution presented to some hospitals was remarkably simple: increase the stated price enough to create the requested discount.

I received calls from hospital CFOs describing these conversations. A hospital that had been offering a legitimate six percent reduction was suddenly being asked for something closer to 50 percent. When the CFO explained that such a discount would put the hospital underwater, the response was effectively: raise the charge.

Once that happened, the discount stopped being an economic result and became a marketing instrument. A 50 percent discount sounds better than a 30 percent discount, but that tells us very little unless we know the number from which it is being taken. Half off an inflated charge can still cost considerably more than a smaller discount applied to a reasonable charge.

I saw this demonstrated repeatedly. Employers left smaller networks because a national carrier promised a larger discount. I would contact some of those employers the following year and ask a simple question:

**What was your COBRA rate before the change, and what is it now? COBRA rates reflect the underlying plan cost. Despite the improved “discount,” I cannot recall one of those employers reporting an actual cost reduction.**

The response was usually that the plan had experienced bad claims. That may have been true, but it did not explain why the celebrated improvement in discounts never appeared in the employer’s cost. Eventually, more employers began to recognize the pattern. They could move from one large carrier to another, receive a new discount analysis and still watch their costs continue in the same direction.

The hospital market was consolidating at the same time. Smaller hospitals closed or merged, major systems gained pricing power, and much of healthcare shifted from inpatient to outpatient settings. Insurance companies also consolidated. A market that once included scores of meaningful alternatives became dominated by a handful of national carriers and a few strong regional organizations.

By approximately 2010, the large carrier had refined its proposition. The employer was offered an enormous national network, a familiar name on the identification card and the assurance that employees could walk into almost any hospital without difficulty.

The fully insured industry understood something that many advocates of self-funding did not: **people do not buy healthcare entirely by arithmetic.** They buy it much as they buy other complicated products. They respond to brands, familiarity, presentation, perceived quality and the fear of making an unusual choice that may later need to be defended.

An expensive hospital benefits from the same psychology as an expensive consumer brand. First, the high price supports the perception of exceptional quality. Then a large discount makes the buyer feel clever for obtaining access to it at a preferred rate. If a lower-cost alternative is introduced, the immediate suspicion is that something must be missing. Otherwise, why would it cost less?

The mathematics can be absurdly straightforward. Suppose one hospital charges 300 percent of Medicare and provides a 50\$ discount. The plan pays 150% of Medicare. Another hospital charges 200% of Medicare and provides only a 40% discount. The plan pays 120% of Medicare. The second hospital has the smaller discount and the lower final cost.

I once presented essentially that comparison during a meeting. The less expensive hospital was approximately 15 minutes farther away and provided comparable care. The consultant's objection was that its discount was only 40 percent. I asked whether the employer would rather pay 150 or 120. The discussion ended there, but the plan continued to be impressed by the larger percentage.

The spreadsheet used in a large request for proposal is often structured around the advantages of the largest carrier. A large network discount receives a prominent value. The ability to prevent an unnecessary service, move an infusion out of a hospital or direct an employee to a more appropriate facility is harder to reduce to one impressive number. Therefore, the large carrier tends to win the spreadsheet even when a smaller administrator, network or pharmacy benefit manager later produces better actual results.

A person involved with a consortium of very large employers once made an observation that stayed with me. When the national carriers and large consulting firms completed their financial comparisons, the smaller independent organizations almost never looked better on paper. When an employer nevertheless selected the smaller organization, however, its actual performance was often materially better.

***One might expect evidence like that to produce a rapid migration. It does not. Employers move slowly because the spreadsheet is only part of the decision.***

The recognizable logo protects the person making the recommendation. If costs rise under a national carrier, the employer can say it selected one of the largest companies in the market. If a problem occurs after choosing an unfamiliar organization, the decision itself may be questioned.

**That is the comfort premium.** The large carriers and consulting firms have spent decades learning how to deliver an orderly experience.

They produce attractive reports, sophisticated presentations and extensive data analyses. Their representatives know how to read a room, manage executive expectations and maintain relationships. They know when to call, whom to reassure and, in many cases, whom to invite to the golf course.

**I once met with the president of a company who had previously worked for a highly aggressive self-funded employer.** His former CEO pursued healthcare savings with considerable force. The company challenged providers, pushed vendors and took an active role in the plan. It saved a great deal of money and employees received the care they needed, but the process was not quiet. There were disputes, complaints and occasional conversations between the CEO and hospital leadership.

When this executive later became president of another company, he encountered a large carrier, a large consulting firm and a much calmer benefits operation. Employees recognized the network.

The consultant delivered polished reports. Problems rarely reached his desk. The plan was more expensive, but the experience was smoother, and he concluded that fully insured healthcare was superior to self-funding.

His conclusion was understandable but incomplete. He was not comparing fully insured healthcare with self-funding. He was comparing an orderly fully insured plan with one unusually combative version of self-funding. Those are not the only two choices.

**A properly managed self-funded plan does not need to operate through perpetual confrontation.**

**The employer can use an independent administrator, practical navigation, targeted clinical programs, transparent pharmacy arrangements and on-going claims oversight without turning every medical bill into a corporate dispute.**

**Good management is supposed to remove unnecessary friction, not manufacture it.**

I can point to a small municipal plan that remained self-funded for nine years and saved a little more than \$2 million despite doing almost nothing sophisticated from a cost-containment standpoint. The plan covered certain individuals that many employers would not ordinarily include, and it was about as passive as a self-funded plan could be. Self-funding alone removed enough insurance cost to produce meaningful savings.

An employer that becomes self-funded and continues behaving as though it were fully insured has accepted the risk without using the tools that make the risk manageable. That is not a strategy. It is merely a change in who pays the bill.

A product may be labeled self-funded while preserving much of the carrier's underlying economic structure. The carrier may control the network, pharmacy arrangement, provider relationships, data and affiliated administrators. In such an arrangement, the employer may carry the claims risk while many of the financial incentives remain elsewhere.

True self-funding is valuable because it permits the employer to assemble the plan deliberately.

A **nurse navigator** can guide employees toward appropriate care. An infusion program can move suitable treatment from an expensive hospital setting to the home. A transparent pharmacy arrangement can reduce the original cost rather than celebrate the return of a portion of an overpayment. An independent administrator can evaluate these decisions from the employer's side of the transaction.

A **rebate** is too often presented as evidence of savings. In elementary terms, however, a rebate means the plan paid more initially and received some of its money back later. That may be preferable to receiving nothing, but it should not be confused with paying the correct amount in the first place.

And by the way, **the fully insured renewal follows the same discipline of presentation.** The initial increase establishes the problem. The negotiation then produces a smaller increase, allowing the final result to be presented as a concession. An employer presented with 20 percent and renewed at 10 percent may feel that its broker recovered 10 points. Yet the employer is still paying 10 percent more, often without correcting the causes of the increase.

I have heard executives describe performance as good because their costs were only slightly above trend. But "slightly above trend" is not good performance when the trend itself is unsustainable. Flat may be good. Below trend may be an improvement. Above trend is simply a more orderly way to lose ground.

Then the national networks arrived, and the arithmetic began to change. Large carriers demanded discounts that hospitals said they could not afford. The solution presented to some hospitals was remarkably simple: increase the stated price enough to create the requested discount.

I received calls from hospital CFOs describing these conversations. A hospital that had been offering a legitimate six percent reduction was suddenly being asked for something closer to 50 percent. When the CFO explained that such a discount would put the hospital underwater, the response was effectively: raise the charge.

This is why we developed **the J.P. Farley Paycheck Index.**

The real result of a health plan does not live in a discount percentage, a rebate guarantee or a consultant's projection. It appears in what the employer and employee ultimately pay. If better management allows the employer to avoid another contribution increase or another thousand dollars of deductible, that difference remains available to the employee as spendable income.

Economically, it belongs in the same conversation as compensation. The lesson is not that fully insured carriers have succeeded by accident. They have identified what employers value and built an effective system around it. They offer familiarity, apparent scale, smooth presentation and relief from visible responsibility. Independent self-funded organizations should study those strengths rather than pretend they do not exist.

**But employers should understand what they are purchasing.** A quiet plan is not necessarily an efficient plan. A celebrated discount is not necessarily a lower price. A familiar logo may slightly reduce complaints, but it does not reduce a hospital charge on employee's credit card or improve the site of care.

## The J.P. Farley Paycheck Index



J.P. Farley Corporation, a leading third-party administrator of self-funded healthcare plans, announces the launch of the **J.P. Farley Paycheck Index** - a practical, human-centered tool designed by CEO and founder Jim Farley to help employers understand the true impact of their health plans on employees' take-home pay.

While most employers evaluate health plans by looking at premiums, deductibles, and renewals, these numbers don't always reflect the reality employees face (specifically, lowest paid employees in the organization). The most pressing question for many is: ***"How much of my paycheck will I actually keep when I need to use my health plan?"***

The Paycheck Index is built to answer this question. It offers business leaders, CFOs, HR professionals, and benefits consultants an easy way to see, before they renew or change a plan, how much of an employee's net pay is at stake.

The Index evaluates three everyday healthcare scenarios:

- An emergency room visit with an MRI
- A benchmark treatment for a chronic condition
- A broken bone

They're the kinds of situations employees and families commonly encounter.

### WHAT YOU WILL LEARN:

**How to measure  
healthcare exposure  
in weeks of net pay**

**How to uncover  
employee costs that  
ordinary plan  
reviews often miss**

**What you can  
change to improve  
the plan and lower  
its Paycheck Index**

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INTERVIEW

# The No Surprises Act's Biggest Surprise: You May Not Have To Pay... Yet.

with Christine Cooper and Jack Towarnicky

The No Surprises Act began with a good idea. An employee could choose an in-network hospital and an in-network surgeon, then receive an unexpected bill from an out-of-network anesthesiologist, radiologist, or pathologist whom the employee never chose. Congress wanted to remove the patient from that fight, and on that narrow point, the law made sense. The trouble is that removing the patient from the argument did not remove the bill. It moved the bill into the employer's health plan, where it became less visible, more complicated, and considerably easier to spread across everyone.

Employees may no longer receive the original surprise bill in the mail. Instead, they meet it later through higher contributions, larger deductibles, reduced benefits, and wages their employer can no longer afford to pay. **The surprise did not disappear; it was divided into smaller pieces and handed to the entire covered population.**

The imbalance also strengthens the case for collective purchasing. Providers and dispute specialists operate at scale, while an individual employer ordinarily enters the process one plan and one claim at a time. A buying cooperative can help employers combine purchasing and negotiating power without requiring every plan sponsor to build the same infrastructure alone.



Christine works extensively with No Surprises Act disputes, balance billing, and reference-based pricing. Jack is a veteran ERISA attorney who has spent roughly 40 years working with the law and the fiduciary responsibilities it creates.

The government reportedly expected the independent dispute resolution process to receive approximately 16,000 disputes. Instead, it received millions. Christine cited research estimating that the process has added roughly \$22 billion in costs, including approximately \$2.7 billion paid to the small group of certified entities that decide these disputes.

A mistake of that size is not a rounding error. If you build a restaurant for 100 customers and 10,000 arrive for dinner, you do not have a busy restaurant; you have a different business.

That is essentially what happened here. The IDR process was expected to resolve exceptional cases, but it became a large and profitable industry of its own. Providers hired specialists to submit and prosecute claims, payers hired specialists to defend them, and the organizations in the middle began collecting fees for deciding them.

Ownership and filing concentration deserve attention as well. CMS has reported that TeamHealth, SCP Health and Radiology Partners were among the leading initiating parties and together represented thousands of clinicians across multiple states. Several frequent filers have been backed by institutional investors and operate the anesthesiology, emergency-medicine or radiology practices generating the disputed claims.



That does not establish misconduct, and it is different from saying that the certified IDR arbitrators are owned by those investors. It does show why plan sponsors should examine who generates the claim, who prosecutes the dispute and who earns money at each stage.

Christine described it well: ***“It’s as if someone created a process without ever talking to anyone who actually pays claims.”***

She also explained that plans are seeing claims enter the process that may not belong there at all, including in-network claims. Jack noted that payers have challenged nearly half of the submissions, while only a much smaller percentage have been rejected as ineligible. Because of the volume and the short deadlines, some payers fail to respond, and providers can win by default.

## ***The Statute Requires Payment, but There's No Enforcement***

**“Yes, the statute requires payment within 30 calendar days, but there's no enforcement.”**

That sentence requires careful reading. Christine was not saying that the award disappears or that employers should pretend it never existed. She was describing a gap between a statutory payment obligation and the provider's ability to use the courts to collect the award.

The statute directs the losing party to pay an IDR determination within 30 days, and federal law provides for government enforcement in certain circumstances. But courts have wrestled with whether providers have a private right to sue merely to collect an unpaid award. That is the practical distinction at the center of the conversation: an award may be binding and payment may be required, while the provider's direct path to judicial collection remains limited or disputed.

Christine's proposed approach was conservative rather than reckless. A plan could reserve the entire amount, speak with its attorneys and stop-loss carrier, and retain the funds while the law develops.

***“I think it's reasonable for a plan to not pay the award, but to reserve funds or to talk to their stop-loss carrier - whatever they have to do to protect themselves.”***

That is very different from tearing up the award. The money remains available. The plan does not spend it or pretend it has earned a windfall.

It simply avoids transferring plan assets before determining whether that transfer is necessary and how the decision may affect stop-loss coverage.

My own view is straightforward: if the plan may eventually owe the money, put it aside. Place it in a separate account, pre-serve it, and earn whatever modest interest is available. If the law later provides a clear collection mechanism, the money is there. If the law changes prospectively and the old awards are never pursued, the plan may retain some or all of it.

Congress may eventually complete what it left unfinished. It may create stronger enforcement, impose additional penalties, or establish a clearer judicial process. No one can promise what Congress will do, which is another reason to keep the reserve intact. Guessing what Congress will do is rarely a sound investment strategy.

## ***Do Not Confuse Aggression With Recklessness***

Jack raised another possible strategy: a health plan might exclude out-of-network care entirely, much as traditional HMOs have done. Initially, I found the idea attractive. If out-of-network claims are creating the problem, why not remove the benefit?

[click here to watch the full episode](#)



The difficulty appears when theory meets an operating room. An employee can choose an in-network hospital and surgeon but may have no practical control over the anesthesiologist, radiologist, or pathologist assigned to the case. The patient may not know those providers are out of network, and even if the patient asks, there may be no alternative available.

A traditional integrated HMO can exclude outside care because it generally maintains its own network of physicians for the complete episode. It does not ordinarily tell a patient, “We will cover the surgery, but anesthesia is your problem.” A plan that attempts a broad out-of-network exclusion without providing a realistic in-network option could shift the original surprise bill directly back to the employee.

That may create problems under the No Surprises Act and other benefit rules. It may also produce a plan design that looks clever in a legal memorandum and indefensible when presented to an employee who needed emergency surgery.

Being aggressive means challenging questionable claims, monitoring deadlines, examining eligibility, and protecting plan assets. It does not mean adopting every aggressive idea before understanding where it ends.

Jack summarized the proper attitude in six useful words:

***“Plan sponsors are not potted plants.”***

Employers are allowed to ask questions. They can challenge claims that do not belong in IDR, investigate unusual provider behavior, review who benefits from the process, and demand that their TPA and advisers explain why an award should be paid.

As Jack put it, plans should “fight fire with fire” by retaining professionals who understand not only the final award, but also the eligibility challenges and deadlines that occur much earlier.

Many disputes are won or lost before anyone discusses the amount. If a claim is not eligible for IDR, the best defense is to challenge it immediately. Allowing it to move through the entire process and objecting afterward is like waiting until a house is built to argue about the property line.

The practical requirement is a consistent process. The plan should know who reviews a dispute, who evaluates eligibility, who communicates with the stop-loss carrier, who authorizes a reserve, and who makes the final payment decision. A fiduciary is permitted to exercise judgment, but inconsistent judgment soon begins to look like no judgment at all.

## ***How Frightening Is ERISA?***

The discussion then moved to fiduciary liability under ERISA, and this subject deserves neither panic nor complacency. ERISA has existed since 1974. Government enforcement of health-plan fiduciary duties has not historically been overwhelming, and the Department of Labor has limited resources.

That does not mean ERISA is harmless; it means enforcement tends to concentrate on cases where the conduct is large, obvious, or accompanied by something worse.

People do not usually suffer severe penalties because a routine disclosure was mailed two days late. The serious cases generally contain an “and.” Someone failed to follow the rules and removed money from the trust. Someone ignored a fiduciary duty and personally benefited from the transaction. Someone approved excessive charges and concealed the compensation.

The word “and” does a great deal of work in enforcement.

Jack explained that a fiduciary generally has discretion in administering plan assets. Paying a valid claim according to the plan is not automatically a fiduciary violation. But when something is obviously questionable, the fiduciary also has a duty to defend the plan and avoid erroneous payments.

Employers should not be frightened into believing that every administrative imperfection will lead to prison. They should also avoid believing that limited government enforcement gives them permission to ignore unreasonable fees, hidden compensation, or obvious waste.

## ***The Retirement Plan Warning***

The best way to understand the current health-plan risk is to look at what happened in retirement plans.

Years ago, stockbrokers were often paid whenever securities were bought or sold.

Some stock brokers discovered that they could increase their compensation by repeatedly trading the assets inside retirement accounts. This became known as churning. The participant owned the account, the broker controlled the activity, and every unnecessary trade quietly reduced the participant’s savings.

The fiduciaries responsible for those plans often had no documented process for monitoring the broker. When lawsuits arrived, the problem was not merely that fees had been charged. The problem was that no one responsible for the plan appeared to have asked whether the fees were reasonable or whether the activity benefited the participants.

Healthcare now presents a larger version of the same problem. An adviser may describe itself as independent while receiving payments from the insurance company, administrator, network, pharmacy benefit manager, or another recommended vendor. A service provider may pay a substantial amount simply to appear on a consulting firm’s approved list, then add per-employee or per-claim payments behind the scenes.

**One dollar here and two dollars there sound harmless until they are multiplied across thousands of clients and billions of dollars.** Small percentages become yachts through the persistent magic of multiplication.

The lawyers who brought fiduciary cases against retirement-plan brokers can see that considerably more money moves through health plans. If they establish favorable case law, health and welfare litigation could become much larger than its retirement-plan predecessor. That is the risk employers should take seriously.

## ***What Employers Should Take From This***

The No Surprises Act was intended to protect employees from bills they could neither anticipate nor control. It accomplished part of that goal, but it also created an immense administrative market with its own fees, specialists, conflicts, deadlines, and incentives.

Christine's central point was that an IDR award should not automatically be treated like an ordinary invoice. Jack's point was that fiduciaries have both discretion and responsibility. My conclusion is that employers should be conservative with the law and aggressive with their questions.

Do not ignore an award. Do not spend the reserve. Do not assume that "binding" and "immediately collectible by the provider" mean exactly the same thing. Most importantly, do not pay simply because every vendor in the room has become accustomed to paying.

Jack borrowed a line from the film *WarGames* to describe the IDR process: ***"What a strange game. The only way to win is not to play."***

A health plan cannot refuse to participate in the No Surprises Act. It can refuse to participate blindly. It can challenge eligibility early, monitor deadlines, scrutinize provider behavior, coordinate with experienced counsel, and stop treating every award as a bill that belongs in the next payment run.

The No Surprises Act removed the surprise from the patient's mailbox. It did not remove the cost, and it certainly did not remove the employer's obligation to think.

## ***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.

[jpfarley.com/blog](http://jpfarley.com/blog)



# How Stop-Loss *Stops Paying*

**Deductibles, lasers,  
contract terms and  
misaligned incentives.**

The first webinar I presented in 2026 was called "How a Bad TPA Can Ruin a Good Self-Funded Plan." Naturally, I expected the questions afterward to be about TPAs.

The questions were mostly about stop loss. Brokers wanted to know which carrier they should choose, how much coverage they should buy, and whether there was a safe option. Those are reasonable questions, but they begin too late in the thinking process.

**Before choosing a stop-loss carrier, an employer ought to understand what stop loss is designed to do, what it is not designed to do, and how the people selling it are paid.**

If you get those questions wrong, comparing carriers will not save you. You will merely choose among several versions of the wrong arrangement.

Stop loss is necessary for most self-funded employers. A 100-employee company should not be expected to absorb a million-dollar claim without protection. But necessity does not excuse careless purchasing. Fire insurance is necessary too, but no intelligent property owner would buy a policy without examining what counts as a fire, when the claim must be reported, what the exclusions are, and whether the insurer can exclude the building immediately after discovering faulty wiring.

Yet employers purchase stop loss that way every year.

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**J.P. FARLEY**  
Empowering People. Elevating Thought.

**The first error is elementary: employers are frequently shown the maximum cost of a self-funded plan as though it were the amount they should expect to spend.**

Aggregate stop loss commonly attaches at 125% of expected claims. If the aggregate attachment point is \$1 million, the underlying expected-claims figure is approximately \$800,000. The million-dollar figure represents a ceiling established by the contract. It is not the most likely result. Those are two entirely different numbers.

A maximum is useful because it defines exposure. It becomes misleading when it is used as the operating budget against which self-funding is evaluated. If someone told you that the maximum legal speed on a highway was 70 miles per hour, you would not conclude that every driver averaged 70 miles per hour over the entire trip. Yet that is approximately the reasoning used when maximum claims are presented as expected claims.

**Fear is expensive.** When employers focus on the worst number on the page, they tend to purchase more insurance than the economics justify.

Aggregate coverage protects against the accumulation of many claims across the plan. Specific stop loss protects against a large claim from one individual. Both can serve a purpose. But neither should be purchased simply because the maximum number makes someone nervous.

Insurance should protect against losses the company cannot prudently retain. It should not be used to prepay ordinary, reasonably predictable expenses at an insurance

## ***Sleep Insurance Has a Price***

Years ago, J.P. Farley had approximately 35 employees and carried aggregate stop loss. During one plan year, we had an unusual concentration of medium-sized claims: two employees taking what were then expensive multiple-sclerosis drugs, a couple of births, and several surgeries, including my own hernia repair.

We crossed the aggregate attachment point, but only by about \$30,000.

That was more than 20 years ago, and we have not had another aggregate reimbursement since. If the coverage cost approximately \$15,000 annually, we could have paid more than \$300,000 in premiums over that period to recover \$30,000. Not a very impressive return.

Many employers still buy aggregate coverage because it helps them sleep. I understand that. Liquidity, retained earnings, risk tolerance, and banking relationships differ from one company to another. There are circumstances in which an employer can knowingly accept a poor expected return in exchange for greater certainty. But it should be a conscious purchase of certainty. It should not be sold as an investment that is likely to pay for itself.

**The problem becomes worse when an aggregate claim finally occurs. A carrier facing reimbursement has every incentive to examine the claim closely, determine whether every expense satisfies the contract, and identify anything that can be excluded. It is the predictable behavior of an organization protecting its own capital. The buyer and the carrier are sitting on opposite sides of the table. The employer wants the policy to respond. The carrier is most profitable when it does not. Anyone who forgets that distinction will misunderstand the transaction.**

Specific stop loss is where poor risk management can become particularly costly.

An old stop-loss underwriting guideline I have kept for decades recommends that, for many employers in roughly the 50-to-500-life range, the specific deductible should fall somewhere between 5% and 15% of expected annual claims. The correct number depends on the employer's financial capacity, but the principle has not changed: retain the predictable layer and insure the catastrophic layer.

Suppose a 100-life plan expects \$1.5 million in annual claims. **A 5%-to-15% range would produce a specific deductible between \$75,000 and \$225,000.** Many employers and brokers would instinctively select the \$75,000 option because it appears safer.

But low deductibles create high fixed premiums. The carrier knows that more claims will cross the deductible, **so it prices those expected reimbursements into the policy, adds expenses, and adds a profit margin.** The employer is effectively paying an insurer more than a dollar to reimburse a dollar that the employer could probably have paid itself.

That is not transferring catastrophic risk. It is financing relatively predictable claims through a very expensive intermediary.

In one case, we obtained stop-loss quotes for a 220-life plan at specific deductibles ranging from \$100,000 to \$250,000 in \$25,000 increments. We held the carrier and contract terms constant and compared three numbers at every level:

- Specific stop-loss premium
- Aggregate stop-loss premium
- Maximum claims exposure

**At a \$200,000 specific deductible, the combined maximum exposure was approximately 5% lower than it was at \$100,000.**



The numbers continued improving until approximately \$225,000. At \$250,000, the total exposure began to rise slightly. That cross-over point - not the deductible that produced the most comforting sales presentation - was where the decision belonged.

The broker nevertheless recommended the \$100,000 deductible. It also happened to produce the largest premium and, therefore, the largest commission.

Charlie Munger's observation about incentives applies perfectly here: show me the incentive, and I will show you the outcome.

That does not mean every broker acts improperly or that every commissioned recommendation is wrong. It means that a buyer who refuses to examine compensation is volunteering to remain ignorant of one of the most reliable forces in business.

## Work With Deductibles

The practical test is not complicated. Ask the same carrier to quote **several specific deductibles using the same contract terms**. Then calculate the total cost at every level.

Do not compare only the premiums. Add the specific premium, aggregate premium, and maximum retained claims exposure. Examine the expected cost as well as the maximum cost. Find the point at which accepting another increment of variable risk no longer produces a sensible reduction in fixed expense.

The carrier may not enjoy producing six or seven quotes. That is irrelevant. The purpose of the exercise is not to make the underwriting department comfortable. It is to determine where the employer receives the most rational combination of protection and retained risk.

A deductible that remains unchanged for several years becomes smaller in economic terms as medical costs increase.

Suppose a claim that cost \$75,000 last year costs \$90,000 this year. Under a \$75,000 specific deductible, the first claim produced no reimbursement while the second produces \$15,000. The carrier knows that more claims will penetrate a deductible that is not increasing with medical costs, so the premium must rise accordingly.

This is leveraged trend. The medical claim may rise by one percentage, but the insurer's liability above a fixed deductible can rise much faster.

Employers frequently retain the same specific deductible for five years and then wonder why premiums have escalated. The answer is partly that they are purchasing an increasingly rich insurance policy without making an explicit decision to do so.

**A specific deductible should be reviewed regularly and increased when the employer's claims, revenue, reserves, and financial capacity support the change.** If the deductible never moves while everything beneath it becomes more expensive, the employer is gradually transferring more ordinary risk to the insurer, and paying the insurer to take it.

## ***A 12/12 Contract Does Not Cover a Full Year of Reality***

Contract timing is another area where a lower first-year price can create a much larger problem later.

**A 12/12 contract covers claims incurred during the 12-month policy period and paid during that same period. It sounds like one year of protection. Operationally, it may cover much less than one full year of claims because medical bills do not arrive the day care is delivered.**

A service performed in December may not be processed and paid until February. Under a 12/12 contract, that claim falls outside the first policy year. By comparison, a 12/15 contract allows three additional months for claims incurred during the year to be paid. The 12/12 contract can make the first year of self-funding look artificially inexpensive. Then the first renewal arrives. The employer must add the claims maturity that was missing from year one, medical trend, revised underwriting, and possibly lasers. A company that believed it had performed well can suddenly face an increase of 35% or 40%. Management concludes that self-funding failed. But self-funding may not have failed at all. The first-year proposal simply understated the cost of mature coverage.

## ***The Laser Takes It All***

A laser assigns a higher deductible, or sometimes an exclusion, to a particular claimant whom the carrier expects to generate substantial costs.

Suppose the plan has a \$150,000 specific deductible and an employee is expected to require \$400,000 in treatment next year. The carrier may establish a \$400,000 laser for that individual. If the anticipated cost is \$1.5 million, the laser may reach \$1.5 million or more.

**The known risk is handed back to the employer.** This is why I often describe stop loss as something closer to a line of credit than traditional insurance. The carrier may protect the plan when a catastrophe first appears. Once the risk becomes visible, the renewal can be rewritten so the employer retains much or all of the continuing cost.

I once saw a \$1.5 million laser placed on an infant who had undergone a bone-marrow transplant. We challenged the assumption by asking a rather basic medical question: What was the probability that the child would undergo another bone-marrow transplant the following year? A prior claim is not automatically proof of an identical future claim. Underwriting that merely carries the largest prior number forward is not analysis. It is self-protection with a spreadsheet.

I have also seen deceased employees remain on laser lists. Once a name enters the underwriting machinery, common sense does not always remove it.

Lasers should therefore be challenged claimant by claimant. Ask what diagnosis, treatment pathway, prescription, prognosis, or utilization pattern supports the carrier's estimate. Require the reasoning, not merely the number.

WATCH THE ON-DEMAND WEBINAR  
**"THE FLAT RENEWAL CHECKLIST  
FOR SELF-FUNDED  
HEALTHCARE PLANS"**

by James Farley



***jpfarley.com/events***

## ***Stop Loss May Cover Year One. The Employer Must Prepare for Year Two.***

**The most dangerous misconception is that stop loss permanently solves the large-claim problem.**

**It may solve the unexpected claim in its first year. At renewal, the carrier may laser the claimant, increase the premium, revise the contract, or decline the risk. The employer then discovers that the disease remains while the protection has changed.**

A sensible self-funded plan therefore needs a strategy for managing high-cost conditions, not merely a strategy for insuring them after they appear.

**The first place I would look today is specialty drugs and cell and gene therapies.** Treatments costing hundreds of thousands of dollars are no longer theoretical. Stop-loss carriers know this, and their underwriting increasingly reflects it.

Employers should investigate pharmacy programs, manufacturer assistance where legally available, alternative sourcing arrangements, and separate coverage for certain catastrophic therapies. Fully insured carve-out products already exist for some transplant and cell-and-gene-therapy risks. Risks that are rare, severe, and widely distributed are precisely the risks insurance pools were invented to handle.

### **Transplants deserve similar attention.**

A person normally does not wake up one morning and unexpectedly join a transplant list. The condition develops, testing occurs, and the patient may remain on the list for months. That creates time for the stop-loss underwriter to identify the risk at renewal and impose a laser.

Purchasing appropriate transplant coverage before a claimant appears can prevent the employer from discovering, too late, that the largest foreseeable claim has effectively been returned to the plan.

## ***Centers of Excellence***

Stop loss can reimburse part of a catastrophic claim, but it cannot ensure that the employee receives the right care. That is the role of a Center of Excellence: a hospital, physician group, or specialty program selected for demonstrated expertise in a particular condition. The basic logic is simple. Correct care from the beginning is usually less expensive than paying for the wrong diagnosis, an unsuccessful procedure, and the treatment required to repair the damage.

A smaller employer does not need Walmart's scale to use this model. We worked with a chain of automobile dealerships covering roughly 100 to 200 employees.

A 38-year-old woman had been diagnosed locally with stage-four cancer and was preparing for aggressive treatment. The employer sent her to Mayo Clinic for a comprehensive evaluation, where the diagnosis was reduced to either stage one or no cancer at all. A relatively modest investment in expert review prevented unnecessary treatment, avoided a much larger claim, and spared the employee consequences that could have followed her for the rest of her life.

The level of care should match the seriousness of the case. Complex cancer, transplants, major cardiac procedures, and difficult spine surgeries may justify sending an employee to a national institution. More routine procedures, such as joint replacement, hernia repair, or a cardiac stent, can often be handled through a high-quality regional program within driving distance. National and regional networks give smaller employers access to selected providers and packaged pricing without requiring them to build Walmart's infrastructure.

**The selection should begin with the plan's own data.** An employer with a physically demanding workforce may need strong orthopedic resources, while a sedentary population with diabetes and cardiovascular risk may benefit more from cardiometabolic and cardiac programs.

If two programs offer comparable quality, convenience can break the tie. If the quality is materially different, quality should win. These procedures may occur only once in an employee's life, and correcting a poor result is far more burdensome than traveling farther for the right one.

Finally, the program needs nurse navigation and repeated employee communication. Employees should understand that a Center of Excellence is not a restriction designed to deny care. It is a benefit designed to connect them with physicians and facilities that give them a better probability of a successful outcome.

## Questions To Address

Why the recommended specific deductible is financially appropriate

How the result changes at several higher and lower deductibles

Whether maximum cost is being confused with expected cost

How the contract treats run-in and run-out claims

What assumptions support every proposed laser

How commissions and other compensation change among the options

What programs will address high-cost drugs, transplants, cancer, dialysis, and other foreseeable risks

What the employer will do in year two after a major claimant becomes known

SPOTLIGHT

# You're Self-Funded. But Did You ACTUALLY Leave Fully Insured?

Employers spent years escaping fully insured healthcare. Too many have recreated the same structure inside their self-funded plans - only now they are carrying the risk.

When companies decide to move from fully insured healthcare to self-funding, it is rarely because things are going particularly well. Usually, they have spent years watching renewals climb, absorbing increases they cannot adequately explain and reaching the point where another round of higher contributions, higher deductibles and reduced benefits no longer qualifies as a strategy.

Self-funding appears to offer a way out. And it can.

I have watched employers save substantial amounts of money after leaving fully insured. I have seen companies improve benefits, lower employee costs and finally gain access to information that allows them to understand where their healthcare dollars are actually going. There is a reason self-funding has become such an important alternative for employers trying to regain control of healthcare.

But there is something I increasingly worry about when companies make the transition. They leave fully insured financially without ever leaving it operationally.

The insurance contract changes. The employer begins funding its own claims. Stop loss is purchased. A TPA is selected. Everybody congratulates themselves on becoming self-funded.

Then the company proceeds to organize its new plan exactly the way it was conditioned to organize the old one.

It wants one large organization. One relationship. One phone number. One umbrella underneath which as many services as possible can be placed. Pharmacy, network, claims administration, stop loss, navigation, clinical programs and other services begin getting bundled together because bundling feels efficient. The fewer relationships management has to think about, the better.



We should give fully insured healthcare credit for something it does exceptionally well: it makes an extraordinarily complicated business appear simple.

An employer pays a premium. Employees receive insurance cards. Healthcare happens. The carrier handles an enormous amount of machinery behind the scenes, and the employer largely encounters the financial consequences once a year at renewal.

The renewal may be ugly. It may be 10%, 20% or considerably worse. The employer may have very little ability to determine exactly why the number is what it is. But until renewal, there is an appealing simplicity to the arrangement.

There is also a perfectly rational reason the carrier doesn't spend much time teaching the employer to become an expert in healthcare economics. **The carrier is being paid to manage that complexity. Employers are buying the ability not to manage it themselves.**

The fully insured industry became very good at being the gateway between employers and an extraordinarily complicated healthcare economy. It negotiated with hospitals, built networks, managed contracts and created products that allowed the employer to stand several steps removed from what was actually happening underneath the plan.

Then healthcare became too expensive. Employers began leaving.

And I believe 2026 is going to create another major wave of employers looking seriously at self-funding. Healthcare costs continue to rise faster than employers can comfortably absorb them, and another double-digit renewal has a way of making an alternative that once seemed complicated suddenly look very interesting.

CFOs who might have dismissed self-funding 5 years ago are going to take a different look when the choices become another major increase, another deductible hike, another shift of cost to employees, or taking control of the plan themselves.

However, when employers move to self-funding simply because fully insured coverage is unaffordable, they may treat it like a discount coupon: keep the same healthcare system, change the financing, and expect savings.



For years, companies became accustomed to a particular relationship with healthcare.

"Don't look closely. Somebody else has it."

Twenty or thirty years ago, an employer could move to self-funding, eliminate some insurance-company overhead, gain better visibility into claims, improve purchasing and potentially generate substantial savings without fundamentally redesigning every aspect of the plan. The healthcare economy of 2026 is different.

The sophistication of the organizations selling into employer health plans has increased enormously, and so has the financial magnitude of what they are selling.

Consider what has entered medicine just recently.

In 2025, the FDA approved Zevaskyn, a gene-modified cellular therapy for recessive dystrophic epidermolysis bullosa. Its announced wholesale acquisition cost was approximately \$3.1 million. The same year brought additional expansion of CAR-T therapies into new cancers, continuing a remarkable medical development. Depending on the product, the drug alone can carry a list price of roughly \$370,000 to more than \$500,000 for a one-time treatment, before hospitalization and associated care are included.

Then came additional gene and cell therapies for extraordinarily serious rare diseases. In late 2025, the FDA approved Waskyra, the first cell-based gene therapy for Wiskott-Aldrich syndrome. A wholesale acquisition cost had not yet been published as of July 2026, although a state Medicaid high-cost-drug program classified it as a potential treatment exceeding \$1 million. Itvisma expanded gene-replacement therapy for spinal muscular atrophy to patients two years and older at a wholesale acquisition cost of \$2.59 million for the one-time treatment. In 2026, Kresladi became the first FDA-approved gene therapy for severe leukocyte adhesion deficiency type I. Its manufacturer had not yet disclosed a launch price, and the same Medicaid program identified it as another potential treatment exceeding \$1 million.

The financial problem is that scientific progress does not arrive at an employer's health plan for free. A multimillion-dollar therapy is an abstract healthcare statistic until one person covered by your plan needs it. For a giant corporation with thousands of covered lives, that is a major claim. For a company with 100 or 200 employees, one or two cases can become the financial story of the entire plan year.

## ***The \$1 Million Bill With the 50% Discount***

Suppose a claim arrives at \$1 million and your network proudly produces a 50% discount. On the spreadsheet, that looks terrific. Half a million dollars has disappeared.

But what if the appropriate price for the service should have been \$80,000? The important question is what you were discounting from.

The employer's money is now behind the claim. A spectacular discount against an irrational price can still produce a terrible outcome.

The same principle applies throughout healthcare. A medication may have an enormous list price and a complicated rebate arrangement. A procedure performed in one facility can cost multiples of what clinically comparable care costs somewhere else. An infusion performed in a hospital-owned setting may bear little resemblance financially to the same drug administered in another appropriate setting.

When you were fully insured, the carrier absorbs claims according to the insurance contract and eventually incorporates its experience into your premium. Self-funded employers don't have that luxury.

### ***Self-Funding Contradiction***

This produces what I think is one of the strangest contradictions in employer health-care today.

Companies move to self-funding because they want control. Then, almost immediately, many begin looking for ways to hand that control back to somebody else.

It is understandable. Employers have spent years in a fully insured environment where healthcare arrives as one large product. There is one carrier, one familiar structure and, for the most part, one organization standing between the employer and the enormously complicated healthcare system underneath it. When an employer becomes self-funded, that simplicity disappears. Suddenly there are decisions to make about claims administration, stop loss, pharmacy, networks, navigation, clinical management and a growing list of other functions. The natural reaction is to ask: Can somebody just put all of this back together for me?

The market has heard that question.

So we increasingly see combinations that recreate some of that old simplicity: a stop-loss organization connected to a TPA, a TPA connected to navigation or clinical services, or several otherwise distinct functions assembled under the same corporate umbrella. Instead of five relationships, the employer may have two. Instead of several organizations to manage, there is one larger organization promising to manage much of it.

That is convenient. But employers should understand what they may be giving up in exchange for that convenience, because the underlying premise of self-funding runs in almost the opposite direction.

Much of the opportunity in self-funding comes from taking apart what fully insured bundled together. Instead of purchasing healthcare as one enormous package, the employer gets the ability to examine its components individually: Who should administer my claims? Who should provide my stop loss? Who should manage pharmacy? Who should navigate my employees? Who should provide the network? For each function, the employer can ask a question it had relatively little opportunity to ask before: Who is actually best at this particular job for my plan?

Remember, these are NOT interchangeable businesses.

A great **stop-loss company** has developed expertise in underwriting catastrophic risk.

A great **TPA** has developed expertise in claims administration, plan operations and data.

A great **nurse-navigation organization** has developed an entirely different set of capabilities around clinical advocacy, employee engagement and steering people through care.

There is another issue that deserves even more attention: independence.

Suppose, for example, that a stop-loss organization owns or controls the TPA administering the employer's plan. Or suppose the TPA owns the navigation organization that is supposed to advocate for employees and challenge the way care is being delivered. That structure does not automatically create a conflict, and it certainly does not mean anyone is behaving improperly. But it changes the relationships inside the plan, and employers should be sophisticated enough to recognize that.

An employee ultimately works for the organization that employs them. Their compensation, management structure, performance expectations and career all exist inside that organization.

We would never expect an employee in any other industry to forget who signs the paycheck simply because another party would prefer a different outcome. Healthcare should not be treated as though normal economics suddenly cease to exist.

# ***Still humans at J.P.Farley***

The point of breaking a healthcare plan into pieces is not fragmentation for the sake of fragmentation. I am not suggesting that every employer should accumulate a collection of twenty vendors and spend its life refereeing them. **The point is to create specialization with accountability: select the strongest partners for the functions that matter, make their responsibilities unmistakably clear, connect them operationally and then manage their performance.**

The employer should be the owner of that architecture - not merely a passenger inside somebody else's.

**Because once one organization begins owning or controlling enough of those pieces,** the plan starts looking familiar again. The employer has one major relationship. The inner workings become less visible. Decisions increasingly happen inside the same corporate family. Convenience returns.

And, almost without noticing it, the employer can begin rebuilding the very structure self-funding was supposed to dismantle.

It has recreated a version of fully insured inside a self-funded plan. Except for one rather important difference. This time, the employer is still holding the risk.

Machines are built to follow scripts. But life doesn't always stick to the script. When a real issue arises, an automated system can only lead you to a programmed 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.**

# How J.P.Farley Runs Your Plan

## 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

## 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

## PHARMACY BENEFIT MANAGEMENT SUPPORT

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

## 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

## STOP-LOSS MANAGEMENT

- Manage policy shopping 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

## 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.

## 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

## CARE MANAGEMENT SUPPORT

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

## 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

## 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.  
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and other third-party vendors.



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