BOARD MEETING AGENDA
Wednesday, August 19, 2026 – 2:00 p.m.
2703 NE 14th Street, Ocala, FL 34470

Join Zoom Meeting: https://us02web.zoom.us/launch/jc/84812596055

Conference Line: 1 646 558 8656 Meeting ID: 848 1259 6055

Call to Order		A. Proctor
Roll Call		C. Schnettler
Public Comment		A. Proctor

DISCUSSION ITEMS

Self-Insurance Agency CBG	Pages 2-38	Mark Fox

PROJECT UPDATES

None

MATTERS FROM THE FLOOR

ADJOURNMENT

OUR VISION STATEMENT

To be known as the number one workforce resource in the state of Florida by providing constructive tools and professional supportive services that are reflected in the quality of our job candidates and meet the needs of the business community.

CBG

A Division of: MITIGATE+ PARTNERS

SELF-INSURANCE EXPLORATION PLAYBOOK

A practical framework for visibility, protected risk, and long-term control.

PREPARED FOR

CareerSource Citrus Levy Marion

Response to Self-Insurance RFI

A concise introduction to the enclosed playbook and presentation materials.

July 24, 2026

Sandra Crawford
CareerSource Citrus Levy Marion
2703 NE 14th Street
Ocala, Florida 34470

Subject: Self Insurance RFI

Dear Ms. Crawford and Mr. French:

Thank you for inviting CBG to provide information as CareerSource Citrus Levy Marion evaluates self-insurance. We understand that this RFI is intended to help the Board and management team determine whether self-insurance is a viable path and, if appropriate, build a stronger Request for Proposals.

This response is practical by design. It explains the plan structure, protected risk, data, partners, provider access, employee experience, and procurement choices that matter most. The larger question is not whether CareerSource CLM can copy a traditional self-funded plan. It is whether the organization wants a more transparent, flexible, and actively managed health plan strategy.

Our central belief is simple: self-funding is a financing method, not the strategy by itself. A successful plan requires clear contracts, usable data, strong stop-loss protection, thoughtful plan design, direct provider relationships, and proactive risk management. When those pieces are aligned, leadership gains more control while employees receive clear support.

CBG would welcome the opportunity to present this information in a 60-minute session, including approximately 45 minutes of education and 15 minutes for discussion. We prefer an in-person presentation because the topic benefits from Board dialogue, and Zoom is also available.

Respectfully submitted,

Mark Fox
President, CBG

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How to Use This Playbook

This playbook answers the RFI and gives the Board a clear path from education to procurement.

1 The goal is clarity - not insurance expertise.
Leadership should leave this process knowing what matters, what to ask, and how to choose a plan that is simple to govern and easy for employees to use.

Contents

RFI response map

CAREERSOURCE CLM REQUEST	WHERE ADDRESSED
Structure and requirements	Sections 03-05
Risk mitigation	Section 06
Provider network continuity	Section 07
TPA and PBM functions	Section 08
Data requirements	Section 09 and Appendix A
Plan design options	Sections 10-11

Why CBG Exists

Founded in 2020 to give employers more visibility, control, and purchasing power.

“The system is not going to fix itself.”

Employers have to take control.

The moment everything changed

In 2020, during the COVID-19 crisis, healthcare became personal for CBG President Mark Fox. After losing a family member, he reviewed the medical bills that followed line by line. The experience confirmed what years in the benefits industry had already shown him: employers and families were paying into a system with limited visibility into price, quality, and financial incentives.

A Fortune 500 model, brought down market

CBG’s model draws from the employer-led work of Tom Emerick, who led benefits at Walmart and previously held benefits roles at BP and Burger King. His approach used data, direct provider relationships, Centers of Excellence, and carefully selected independent partners to improve care and change the economics of the plan. At Walmart, the lesson was clear: for a labor-intensive, low-margin employer, healthcare was not merely a benefit expense. It could materially affect the capital available to compete and grow.

What CBG does today

CBG was founded to make those principles practical for employers with 100 to 1,500 employees. We follow the data, protect the plan with the right funding and stop-loss structure, remove unnecessary middle layers, contract directly where it creates value, and actively manage the strategy as the data changes. The goal is not simply to buy a different insurance product. It is to build a more transparent and predictable health plan that protects employees and strengthens the organization.

2020

CBG founded during the COVID-19 crisis

100-1,500

Employees in CBG’s core employer market

ONE PRINCIPLE

Let the data show where the money is going. Then change the plan where the data shows the need.

SEE THE SPEND	CHANGE THE ECONOMICS	MANAGE THE PLAN
Make claims and pharmacy information visible enough to guide decisions.	Use direct provider relationships and aligned contracts where they create value.	Intervene before high-cost claims and improve the strategy as the data changes.

CBG Company Profile

Requested firm information for CareerSource CLM's selection process.

Company principals

CBG is a healthcare consulting firm, not a carrier, TPA, PBM, or commission-driven plan-placement shop. Its leadership model pairs strategic plan architecture with disciplined implementation and proactive risk management.

PRINCIPAL	PRIMARY ROLE
Mark Fox, President	Company vision, employer strategy, plan architecture, cost containment, sales, pricing, and major client strategy.
Vanessa Fox, VP of Operations	Administrative operations, finance, compliance coordination, internal service oversight, and implementation support.

Experience with nonprofit and mission-driven employers

CBG has supported nonprofit and mission-driven employers in evaluating, developing, implementing, and proactively managing self-funded and level-funded health plan strategies. Client names are omitted here to protect confidentiality.

Evaluate
Review the current plan, renewal, enrollment, available data, workforce needs, and maximum protected cost.

Build
Design funding, stop-loss, administration, pharmacy, provider access, direct contracts, and cost-containment pathways.

Proactively manage
Review claims and prior-authorizations, coordinate partners, guide high-cost claim mitigation, and refine the plan throughout the year.

Presentation and educational materials

REQUESTED ITEM	CBG RESPONSE
Presentation length	60 minutes total: approximately 45 minutes of education and 15 minutes for discussion.
Preferred format	In person is preferred; Zoom is available.
Printed materials	This playbook and a companion five-page Self-Insurance Guide will be provided as the educational materials.

CBG's role

CBG helps evaluate the funding model, design the plan, coordinate partners, negotiate direct provider arrangements, conduct open enrollment, educate employees through ongoing engagement, reduce waste, and proactively manage plan performance. CareerSource CLM remains responsible for final plan and governance decisions.

The Decision in Front of CareerSource CLM

The current strategy has limits. A more transparent and controlled future is possible.

WHAT THE CURRENT STRATEGY LIMITS

- Renewal pricing arrives before leadership can see the cost drivers underneath it.
- The organization has limited claims visibility, negotiating leverage, and plan-design flexibility.
- Employees may absorb higher cost even when the underlying purchasing model changes very little.
- The annual renewal becomes the decision instead of one input in a multi-year strategy.

WHAT A MANAGED STRATEGY CAN CREATE

- Leadership sees where the money is going and can act on the largest cost drivers.
- Specific and aggregate stop-loss place clear limits around defined financial exposure.
- Direct provider contracts and high-value pathways remove avoidable middle-layer waste.
- The strategy follows the data each year and closes the gaps the data reveals.

2 The central principle

Self-funding is the financing method. The strategy is the architecture around it: transparent data, protected risk, direct provider contracts, aligned compensation, employee education, proactive claim intervention, and disciplined execution.

Three decisions - in this order

STEP	DECISION	PLAIN-ENGLISH QUESTION
1	Commitment	Does leadership want transparency, control, and a three-to-five-year strategy instead of another annual renewal cycle?
2	Design	What plan structure, risk protection, direct relationships, and support model fit CareerSource CLM?
3	Procurement	What RFP structure preserves competition while rewarding proactive risk management and aligned incentives?

The cheapest plan is not always the lowest-cost plan.

A low first-year price can be attractive, but the better decision is the strategy that produces the strongest five-year cost trajectory, protects employees, and creates predictable results year after year.

Self-Insurance in Plain English

Self-insurance changes how the plan is financed. The real value comes from how the plan is built and managed.

QUESTION	FULLY INSURED	SELF-FUNDED
Who pays claims?	The insurance carrier.	The employer's health plan.
How is cost funded?	A fixed premium is paid each month.	The employer funds actual claims, administration, and stop-loss protection within a defined structure.
Who keeps favorable results?	Generally the carrier.	The employer may retain favorable claim experience, subject to the arrangement. All CBG clients retain 100% of unused claims dollars.
Who carries claim risk?	The carrier.	The employer's plan up to the specific and aggregate stop-loss limits.
How much plan control?	Usually limited by the carrier contract.	More flexibility, data access, vendor choice, and direct contracting when the plan is structured correctly.

What employees experience

Familiar
Recognizable medical benefits, broad provider access, ID cards, and a clear explanation of what is covered.

Supported
One clear place to ask questions, get help before planned care, and understand zero-cost care options.

Protected
The TPA administers claims while CBG coordinates partners, monitors risk, and brings decision-ready information to leadership.

What changes behind the scenes

- CBG brings proven TPA, PBM, network, stop-loss, and care-partner recommendations; CareerSource CLM approves the major selections.
- CBG coordinates and monitors those partners on CareerSource CLM's behalf.
- The plan gains detailed claims and pharmacy reporting and can change strategy as the data changes.
- The plan uses defined monthly funding, specific stop-loss, aggregate stop-loss, and cash-flow smoothing features.
- The plan can add direct provider contracts and targeted cost-containment strategies instead of accepting only an off-the-shelf carrier design.

3 A coordinated operating model keeps the experience simple.
The TPA and CBG sit at the front of the operating model so employees and HR have a clear point of contact, while the specialized partners work together behind the scenes.

What Makes Self-Insurance Viable?

Size alone should not disqualify the conversation. The real issue is whether leadership wants transparency, flexibility, and active control.

Self-funding can be evaluated for employers across a wide range of sizes. CareerSource CLM does not need to wait for a perfect moment or become an insurance expert. It needs a protected funding structure, a reliable way to gather underwriting information, and leadership willing to review plan performance and act on the cost drivers.

The real viability question

Does CareerSource CLM want to keep reacting to annual premiums, or does it want the data, flexibility, and decision rights needed to change the long-term trajectory?

Five practical decision factors

DECISION FACTOR	WHAT LEADERSHIP SHOULD CONFIRM	HOW CBG SIMPLIFIES IT
Leadership commitment	The Board and management will review plan performance during the year and make decisions on the largest cost drivers.	CBG converts plan data into clear recommendations and brings major decisions to leadership.
Underwriting data path	Claims and pharmacy data will be used when available. When fully insured data is limited, secure health risk questionnaires and other permitted underwriting sources can fill the gap.	CBG helps coordinate the questionnaire process and works with the underwriter to obtain a usable risk profile.
Protected funding	Maximum annual liability is clearly defined and compared with the current fully insured cost.	Specific and aggregate stop-loss, a corridor, monthly aggregate accommodation, and specific advance funding can cap exposure and smooth cash flow.
Workforce profile	Enrollment and locations are stable enough to quote and administer the plan.	CBG reviews census and enrollment patterns and designs around the actual workforce.
Employee support	Employees need one simple path for questions, planned care, and zero-cost options.	CBG provides dedicated support, open-enrollment education, and ongoing engagement.

Health questionnaires must be structured and administered properly. They should not request genetic information or be used to determine individual eligibility or individual premiums. Secure handling and privacy protections remain essential.

A Simple Three-Step Evaluation

Gather the right information, compare the five-year trajectories, and decide whether CareerSource CLM wants control.

1. Gather securely

Use claims and pharmacy information when available. If fully insured data is unavailable, use a secure health risk questionnaire and other permitted underwriting inputs. CBG assists with collection and employee communication.

2. Model five years

Compare the current fully insured trajectory with a protected self-funded strategy. Include maximum annual liability and the order in which risk-mitigation strategies may be introduced.

3. Decide on control

Decide whether CareerSource CLM wants data ownership, predictable funding, plan-design flexibility, direct provider relationships, and proactive risk management throughout the year.

What should be modeled

MODEL	WHAT IT SHOULD SHOW
Five-year status quo	Begin with current fully insured cost and apply an illustrative 8% annual trend assumption. This shows the cost of doing nothing and can be sensitivity-tested at higher and lower trends.
Five-year managed strategy	Show maximum protected cost, fixed administration and consulting costs, direct-contract and cost-containment opportunities, and a multi-year strategy for reducing claim frequency and severity.
Maximum annual liability	Use the underwriter's specific and aggregate stop-loss quote to show the worst-case covered cost under the proposed structure.
Strategy sequence	Establish the first-year foundation, then update years two through five as actual claims and pharmacy data reveal where money is being spent.

A five-year view protects the decision from one-year noise.

A temporary fully insured discount may lower the first-year price, but it does not create data ownership, aligned incentives, direct contracting, or a durable risk-management strategy. The question is whether the long-term opportunity is large enough to justify change.

Trend reference: WTW reported a projected 8.0% U.S. employer healthcare cost trend for 2026 after planned changes and 9.1% before plan changes. The 8% illustration should be adjusted to CareerSource CLM's actual renewal history and market conditions.

Plan Structure and Governance

The plan should be coordinated through clear roles.

ROLE	PLAIN-ENGLISH RESPONSIBILITY
CareerSource CLM Board and leadership	Approve the plan, select major partners, set the organization's risk parameters, and review results and plan performance.
Independent plan strategist / consultant	Evaluate the model, design the plan, coordinate partners, implement data-based cost-containment strategies, monitor execution, and interject when prior-authorization or large-claim activity creates an opportunity.
Third-party administrator (TPA)	Process eligibility and medical claims, provide customer service, support appeals, and produce reporting.
Pharmacy benefits manager (PBM)	Administer prescription benefits, pharmacy access, pricing, formulary, specialty drugs, and pharmacy reporting.
Stop-loss carrier	Reimburse covered claims that exceed the policy's specific or aggregate thresholds.
Provider network and care partners	Provide broad access to care and selected direct, bundled, or high-value pathways.
Compliance and legal support	Confirm plan classification, documents, notices, reporting, and legal requirements.

4 CareerSource CLM keeps strategic control.
Contracts should preserve data ownership, complete compensation disclosure, meaningful audit rights, and practical transition rights. The employer approves the strategy; CBG coordinates execution.

Governance can stay simple

CADENCE	WHO REVIEWS	PURPOSE
Monthly	CBG and administrative partners	Handle operational issues, prior-authorizations, high-cost activity, and open actions without burdening leadership.
Quarterly	HR and Finance	Review claims trends, financial performance, employee experience, and recommended actions.
Biannually	Executive leadership	Review first-half and second-half results, successes, challenges, and adjustments that can improve the remaining plan year.
Annually	Leadership with CBG	Review claims trends, vendors, stop-loss, plan design, contracts, measurable outcomes, and the next year of the multi-year strategy.

Classification checkpoint: Before final design, CareerSource CLM should confirm with qualified counsel and compliance advisers whether the plan is treated as a private-sector ERISA plan, a non-federal governmental plan, or another arrangement. That classification affects governance and compliance requirements.

Risk Protection in Plain English

Protect the organization first. Then use the plan's flexibility to reduce the frequency and severity of claims.

Three protections that create financial predictability

PROTECTION	WHAT IT DOES	SIMPLIFIED EXAMPLE
Specific stop-loss	Caps the employer's covered cost for one individual above a stated deductible.	With a $50,000 specific deductible and a $550,000 eligible claim, the employer funds the first $50,000 and the specific policy reimburses the remaining $500,000, subject to the contract.
Aggregate stop-loss	Caps total eligible claims for the covered group above an annual attachment point.	With a $1,000,000 aggregate attachment point and $2,000,000 of eligible claims, the employer funds the first $1,000,000 and the aggregate policy reimburses the next $1,000,000, subject to the contract.
Cash-flow smoothing	Monthly aggregate accommodation and specific advance funding can reimburse qualifying excess claims during the year instead of waiting until year-end.	A common aggregate corridor is 125% of expected claims, creating a 25% cushion. Accommodation and advance features can make monthly funding more stable and predictable.

The examples are intentionally simplified. Final policy definitions, eligible claims, deductibles, exclusions, contract periods, and reimbursement terms control.

The goal is not to accept more risk.

CBG compares the quoted maximum annual liability with the current fully insured cost and structures the plan so leadership can see the defined worst-case covered cost before making a decision.

Risk management continues after the policy is placed

- CBG reviews prior-authorization and large-claim activity so high-cost care can be redirected, negotiated, or supported before the claim escalates.
- Direct contracts, bundled care, specialty-drug strategies, and alternative coverage pathways can reduce high-cost exposure before renewal.
- The plan is adjusted as new data reveals where the largest opportunities exist.

Stop-Loss Contract Safeguards

The policy should fit the plan, support predictable cash flow, and create a clear path for known high-cost risks.

CONTRACT ITEM	PRACTICAL APPROACH
Contract basis	One common first-year structure is 12/12, covering eligible claims incurred and paid during the policy year. In later years, a 24/12 or another mature contract basis may cover prior-year run-out and current-year claims. The quoted contract controls.
Terminal liability option	Specific or aggregate terminal liability can extend protection after the stop-loss policy ends. CBG generally prefers contracts that preserve the option to purchase this protection later rather than paying for it before it is needed.
Lasers and known risk	A laser identifies a claimant-specific risk so the financial tradeoff can be modeled. It can also show the consultant exactly where mitigation, negotiation, alternative coverage, or direct care intervention is needed.
Risk pools and captives	Pooling can improve stability when fees, claim sharing, governance, data access, renewal rules, and exit terms are transparent. The arrangement should also require cost-containment rules so disciplined employers are not subsidizing avoidable claims created by poor plan management.

Stop-loss questions that should be answered in writing

#	QUESTION
1	What are the specific and aggregate thresholds and maximum covered liability?
2	Are there lasers, exclusions, aggregating-specific features, or special limits?
3	What contract period applies to current claims and prior-year run-out?
4	Does the policy include specific advance funding and monthly aggregate accommodation to stabilize cash flow?
5	What is the consultant's strategy if a claimant is expected to remain high cost at renewal?
6	Can the consultant negotiate the risk, redirect care, use direct arrangements, or evaluate alternative coverage before the next plan year?

Provider Access: Keep What Matters, Improve What Costs Too Much

Broad access is a starting point. Direct contracts and high-value pathways create the better economics.

The goal is not to preserve every existing provider arrangement at any price. It is to protect essential access while improving quality, cost, and continuity. Some provider changes may be necessary when reimbursement is excessive or a better care pathway is available.

5 A national network provides access - not the entire strategy.

CBG can rent a broad national network for familiarity and geographic reach, then add direct provider contracts, bundled services, and single-case agreements that improve net cost and patient experience.

A three-step access plan

1. Listen

During a secure health questionnaire or provider-preference survey, ask employees to identify the physicians and facilities that matter most to them.

2. Compare

Compare available national networks, provider overlap, geographic gaps, and the providers employees specifically identified.

3. Build

Add direct contracts, bundled care, high-value pathways, and single-case agreements to create a custom network around the gaps and cost drivers.

Ways to maintain and improve access

APPROACH	HOW IT HELPS
Rent a national network	Provides broad geographic access and a familiar provider-search experience.
Use direct provider contracts	Creates clearer pricing, removes avoidable middle-layer fees, and strengthens the patient-provider relationship.
Add bundled and zero-cost care pathways	Offers selected services through a coordinated package with no employee out-of-pocket cost when used correctly.
Use single-case agreements	Preserves access for a specific provider or situation when a standard network arrangement is not the best fit.

A discount off an unknown starting price is not the same as a low net cost.

Provider access matters, but the fiduciary question is whether the plan is purchasing quality care at a defensible total cost.

TPA and PBM Roles and Selection

Administration and strategy are different jobs. Each partner should have a clear role and aligned economics.

TPA: medical administration

Eligibility, medical claims, ID cards, customer service, appeals support, reporting, vendor integration, and compliance coordination.

PBM: pharmacy administration

Prescription claims, pharmacy access, drug pricing, formulary, specialty drugs, clinical programs, and detailed pharmacy reporting.

Non-negotiable requirements

#	REQUIREMENT
1	CareerSource CLM owns and can access its medical and pharmacy data.
2	The TPA discloses every source of direct and indirect compensation.
3	The PBM is paid through one flat PEPM or per-script administrative fee and receives no other direct or indirect revenue, spread, retained rebates, or data-monetization income.
4	The plan has meaningful audit rights and clear, detailed reporting.
5	The partners can integrate with independent networks, direct contracts, and high-value care pathways.
6	Service, data-transfer, and transition terms are clearly defined.

Selection questions

CATEGORY	QUESTION
Service	Who answers employee and HR questions, and what service commitments apply?
Data	What claim-level feeds and reports are available, how often, and in what format?
Cost control	What levers does the partner actively manage to lower the frequency and severity of claims?
Integration	Can the partner work with independent networks, direct provider contracts, pharmacy partners, and care pathways?
Contract	What audit, data ownership, compensation, and transition rights does CareerSource CLM retain?

Administration is not the strategy.

CareerSource CLM should not depend on a TPA, PBM, carrier, or captive arrangement to create its cost-containment strategy. The plan strategist should be paid directly and only by CareerSource CLM, reject all third-party revenue, and bring aligned TPA, PBM, stop-loss, network, and care options to the table.

Data Needed for a Useful Analysis

Use available claims data when possible. When fully insured data is limited, create a secure underwriting path instead of stopping the process.

Phase 1: feasibility and underwriting information

DATA CATEGORY	WHAT TO REQUEST
Workforce	Employee census, enrolled employees, dependent tiers, locations, eligibility rules, and enrollment history.
Current plan	Plan summaries, deductibles, copays, coinsurance, contribution strategy, and benefit documents.
Cost	Current rates, renewal history, employer cost, and known plan-related fees.
Medical experience	Preferably 24-36 months of aggregate claims, large-claim summaries, and utilization reports, if available.
Pharmacy experience	Total drug spend, specialty drug information, top 25 drugs with cost, top therapeutic classes, and rebate information, if available.
Provider preferences	Key physicians and facilities identified through available utilization data or a secure provider-preference question during the health risk assessment.

When complete claims data is unavailable

CareerSource CLM can still move forward. A secure health risk questionnaire can give the stop-loss underwriter the information needed to price the risk and identify high-cost conditions. The questionnaire process should be clearly explained, administered through a secure channel, separated from employment decisions, and designed to avoid prohibited genetic information.

6 Data is the feedback loop that makes the plan smarter.

Once the plan is self-funded, CareerSource CLM should receive detailed medical and pharmacy reporting throughout the relationship and retain access after a transition. The data allows CBG and leadership to identify where money is being spent, measure outcomes, and change strategy as the risk changes.

Data ownership should be an RFP requirement

- Regular detailed medical and pharmacy reporting in usable formats.
- Lawful sharing with the employer's authorized advisers and business associates.
- Access during the relationship and after termination.
- Audit rights and complete documentation of direct and indirect compensation.

Plan Design: Change Only What Creates Value

Customization means changing the parts that improve cost, quality, access, or control - not adding programs for the sake of adding programs.

7 Design rule: eliminate before adding.
Remove avoidable fees, poor contracts, hidden revenue, and unnecessary waste first. Add a new solution only when it addresses a real cost driver and can be measured.

DESIGN AREA	SIMPLE APPROACH
Core medical benefits	Keep deductibles, copays, coinsurance, and covered services familiar where that supports the workforce, then adjust only where the economics justify it.
Provider access	Use a broad national network as a foundation, then add direct contracts, bundles, and single-case agreements.
High-value care pathways	Offer selected services through high-value arrangements at no employee out-of-pocket cost.
Pharmacy strategy	Use transparent pricing, specialty-drug controls, clinical review, and alternative sourcing when appropriate.
Employee contributions	Align employer and employee cost sharing without shifting avoidable plan waste to employees.
Navigation and support	Give employees one clear place to get help before planned care.
Wellness and incentives	Use only when tied to a clear objective, simple action, and measurable result.

CBG's preferred architecture

Foundation
A stable major medical plan and broad provider access.

Protection
Specific and aggregate stop-loss, strong contracts, and a defined maximum liability.

Direct access
Direct provider relationships and zero-cost pathways that remove avoidable middle-layer waste.

Proactive management
Employee education, prior-authorization review, claim intervention, and annual strategy updates based on data.

The strongest plan is not the plan with the most vendors. It is the plan with the fewest moving parts needed to protect employees, control risk, and address the real cost drivers.

Employee Experience and Change Management

The plan can be strategically coordinated behind the scenes. Simplicity is key for employees.

Employees should know only three things

1. What is covered?	2. Who do I call?	3. What do I do next?
Explain benefits in plain language without teaching employees insurance mechanics.	Provide one clear support path for plan questions, planned care, and zero-cost programs.	Give a short action step before the employee schedules planned care.

How CBG supports the transition

PRINCIPLE	WHAT IT LOOKS LIKE
Preserve familiarity	Keep recognizable benefits and broad provider access where it supports the plan.
Use one front door	Employees receive a clear CBG support path instead of navigating multiple partners.
Communicate in stages	Explain why the plan is changing, what stays familiar, what improves, and what employees should do next.
Make value visible	Show employees where selected services are available at no out-of-pocket cost.
Equip HR	CBG provides dedicated account executives to HR leadership and handles employee education and support.
Measure the experience	Track problems and praise, look for trends in either direction, and improve communication or service where needed.

8 The emotional outcome

Employees should feel confidence and certainty that the health plan will support them and their families. They should understand that the employer cares about quality, access, and affordability - and that selected zero-cost care options are available when they need them.

Communication sequence

STEP	MESSAGE
1	Leadership explains why the organization is changing the strategy.
2	CBG shows what stays familiar and what will improve.
3	Employees receive clear plan materials, ID-card guidance, and one support contact.
4	CBG conducts open-enrollment education and answers employee questions.
5	Employees are taught what to do before planned care and how to access zero-cost options.
6	CBG continues education and engagement throughout the year.

Implementation Roadmap

A disciplined transition starts with a written multi-year strategy, clearly defined partners, and governance that supports the employer's fiduciary responsibilities where applicable.

STAGE	ILLUSTRATIVE TIME	KEY RESULT
1. Feasibility	3-4 weeks	Collect available data, coordinate health questionnaires if needed, compare the five-year trajectories, and brief leadership.
2. Board direction	1-2 weeks	Confirm the desired strategy, procurement path, and decision authority.
3. RFP and procurement	4-8 weeks	Issue a strategy-led RFP, answer questions, score responses, and select finalists.
4. Contracting	2-3 weeks	Finalize TPA, PBM, network, stop-loss, data, compensation, and service terms.
5. Implementation	2-4 weeks	Build eligibility, claims, pharmacy, provider, plan documents, and operating workflows.
6. Education and go-live	2-4 weeks; overlaps	Conduct open enrollment, distribute materials, confirm support paths, and launch ongoing engagement.

Operating rhythm after launch

MONTHLY	QUARTERLY	BIANNUALLY	ANNUALLY
CBG operational risk review: prior-authorizations, high-cost activity, claims issues, and open actions.	HR and Finance: plan performance, claims trends, employee experience, and recommended actions.	Leadership: successes, challenges, midyear adjustments, and renewal positioning.	Claims trends, stop-loss, contracts, plan design, compliance coordination, and the next year of the multi-year strategy.

9 Benefits Champion

CareerSource CLM should designate one internal Benefits Champion. This person becomes the trained internal liaison, escalation point, and designated decision-maker within approved authority. The role reduces management by committee and helps the organization make timely plan decisions while preserving Board oversight.

The timeline is illustrative and assumes several activities overlap. Actual timing depends on procurement rules, plan effective date, data collection, vendor requirements, and legal or compliance review.

How to Write a Better Future RFP

The future RFP should create competition around outcomes, transparency, and proactive risk management - not force every firm into the same traditional model.

REMOVE FROM THE RFP

- Mandatory bundling of strategy, TPA, PBM, network, and stop-loss.
- A requirement that the bidder be paid through carrier or vendor commissions.
- Vague data ownership or compensation language.
- Lowest first-year price as the primary definition of value.

REQUIRE IN THE RFP

- A clear feasibility process and five-year health plan strategy.
- A multi-year strategy to lower the frequency and severity of health claims.
- Unbundled options and one fully disclosed compensation structure.
- Data ownership, audit rights, detailed reporting, and transition rights.
- Specific and aggregate stop-loss terms and maximum annual liability.
- A simple employee support and communication model.

Suggested evaluation framework

EVALUATION CATEGORY	SUGGESTED POINTS
Strategy	15
Feasibility	10
Risk protection and financial modeling	20
Contracts, data, compensation, and transparency	20
Provider access and employee experience	15
Implementation and proactive risk management	10
Overall value	10

The RFP should buy a strategy - not a product list.

Respondents should explain how they will determine what CareerSource CLM needs, how they will protect risk, and how they will proactively manage the frequency and severity of claims. Vendor names are not required when they are proprietary to active clients only.

Board Decision Checklist

A short list of questions that separates a managed strategy from a conventional quote.

BOARD QUESTION	STATUS	WHY IT MATTERS
Can the five-year status quo and managed-strategy trajectories be compared?	YES / NO / TBD	The Board needs to understand both the cost of doing nothing and the opportunity created by change.
Can maximum annual liability be defined and kept at or below an acceptable level?	YES / NO / TBD	The worst-case covered cost should be visible before the decision is made.
Does the stop-loss structure include features that support predictable cash flow?	YES / NO / TBD	Specific advance and monthly aggregate accommodation can reduce monthly volatility.
Can essential provider access be preserved while direct relationships and high-value options are added?	YES / NO / TBD	Access and fiduciary purchasing discipline must work together.
Will CareerSource CLM own its data and receive regular detailed reporting?	YES / NO / TBD	Control requires visibility.
Will the consultant accept one flat-rate revenue stream paid directly by CareerSource CLM and reject all other revenue?	YES / NO / TBD	Aligned financial incentives are crucial. The consultant should work only for the employer.
Will all TPA, PBM, stop-loss, network, and partner compensation be disclosed?	YES / NO / TBD	Hidden economics weaken oversight and distort recommendations.
Will employees have one clear support path and access to selected zero-cost care?	YES / NO / TBD	The plan must protect both the employee experience and the employer's financial strategy.
Will leadership review performance during the year and act on cost drivers?	YES / NO / TBD	Self-funding creates value through active governance, not annual renewal review.
Does the RFP preserve unbundled and proprietary approaches?	YES / NO / TBD	The procurement structure should not decide the solution before respondents explain their strategy.

Three possible outcomes

KEEP THE STATUS QUO

Remain fully insured and accept limited data access, less flexibility, continued dependence on annual carrier renewals, and fewer tools to address the underlying cost drivers.

DESIGN THE STRATEGY

Complete the five-year comparison, confirm maximum liability, define the operating model, and finalize the requirements for procurement.

PROCEED TO PROCUREMENT

Issue a strategy-led RFP that rewards data ownership, protected risk, aligned compensation, direct contracting, and proactive claim management.

CBG's recommendation: make the decision as a three-to-five-year health plan strategy, not a one-year renewal exercise. Meaningful results can begin in year one, but predictability and sustained trajectory change require consistent execution over multiple years.

Appendix A - Minimum Data Request Checklist

A phased request designed to obtain useful information without losing momentum.

Organization and enrollment

- Employee census with age or date of birth, ZIP code, coverage tier, and employee/dependent status.
- Eligible employees, enrolled employees, dependents, COBRA participants, retirees if applicable, locations, eligibility rules, and enrollment history.

Current plan and cost

- Current plan summaries, SBCs, benefit schedules, plan documents, contribution strategy, current rates, renewal rates, and at least three years of renewal history.
- Known administrative, network, pharmacy, consultant, and plan-related fees.

Medical and pharmacy information

- Preferably 24-36 months of aggregate medical claims, large-claim summaries, and utilization reports, if available.
- Pharmacy spend, specialty drug reports, top 25 drugs with cost, top therapeutic classes, rebates, and utilization information, if available.
- When claims information is unavailable, a secure health risk questionnaire and permitted underwriting data sources coordinated with the stop-loss underwriter.
- Provider preferences identified through available data or the health risk questionnaire.

Contracts and operations

- Current carrier, network, broker, pharmacy, telemedicine, and care-management agreements or summaries.
- Known service issues, employee praise, access concerns, HR support needs, procurement rules, conflict disclosures, approval requirements, and implementation deadlines.

A Secure-data rule

Detailed data should be exchanged only through encrypted secure email or through a password-protected process of encrypted data exchange.

Minimum viable starting package

Census + enrollment + current plan + current rates + renewal history + available aggregate medical and pharmacy reports + a secure health risk questionnaire process when claims data is unavailable.

Appendix B - Sample Future RFP Questions

Questions that encourage clear thinking without prescribing one bundled solution.

CATEGORY	SAMPLE QUESTION
Strategy	Explain how you would determine whether self-funding is viable and how you will actively mitigate the frequency and severity of large health claims.
Independence	Identify every source of direct and indirect compensation and every financial relationship with proposed partners.
Structure	Show which services are bundled and which can be selected, replaced, or contracted separately.
Risk	Provide maximum annual liability, stop-loss terms, lasers, contract basis, terminal-liability options, specific advance, and aggregate accommodation.
Data	Confirm CareerSource CLM's ownership, access, frequency, detail, format, audit rights, sharing rights, and post-termination access.
TPA	Describe claims processing, customer service, appeals, reporting, and integration.
PBM	Describe pricing method, formulary, specialty-drug strategy, audit rights, termination terms, and every source of direct and indirect revenue.
Network	Explain how current provider use will be analyzed and how provider continuity will be preserved as best as possible.
Cost containment	Identify the cost drivers you expect to evaluate and how your proposed strategies will lower claim frequency and severity.
Employees	Explain how employees will receive one simple support path, ongoing education, and access to selected zero-cost care options.
Implementation	Provide a detailed implementation schedule, responsible parties, and communication plan.
Governance	Describe quarterly, biannual, and annual reporting and the decisions each report will support.
Compliance	Identify which party coordinates each plan document, notice, reporting, and compliance responsibility.
References	Provide relevant, comparable experience while protecting confidential client and participant information.

B Keep the RFP open enough to learn.

CareerSource CLM should define the outcomes, safeguards, transparency, and compensation rules it requires. Respondents should be allowed to explain different ways to achieve them.

Sources and Reference Notes

Selected public sources used to support this educational response.

1. CareerSource Citrus Levy Marion - Self-Insurance RFI
The two-page RFI that defines the requested information and presentation requirements.

2. WTW - Employers Prepare for Health Plan Changes as 2026 Costs Rise
Reports a projected 9.1% U.S. employer healthcare cost trend before plan changes and 8.0% after plan changes for 2026.

3. HM Insurance Group - How Stop-Loss Works
Plain-English description of specific stop-loss, aggregate stop-loss, and the aggregate corridor.

4. HM Insurance Group - Stop-Loss Features and Options
Describes contract periods, specific advance funding, monthly aggregate accommodation, and terminal-liability options.

5. U.S. Department of Labor - HIPAA Portability and Nondiscrimination FAQs
Explains that a health questionnaire may be used if it does not request genetic information or determine individual eligibility, benefits, or premiums.

6. HHS - Employers and Group Health Plan Information
Explains the separation between the employer and group health plan and the conditions for protecting plan health information.

7. U.S. Department of Labor - Understanding Fiduciary Responsibilities
Overview of group health plan structure, service-provider selection, monitoring, compensation, and fiduciary responsibilities for ERISA-covered plans.

8. Centers for Medicare & Medicaid Services - Gag Clause Prohibition Compliance Attestation
Federal information regarding contractual restrictions on access to cost, quality, and claims information.

9. Never Pay the First Bill - Marshall Allen
Educational reference regarding medical billing, pricing opacity, and active healthcare purchasing.

10. The Price We Pay - Marty Makary, MD
Educational reference regarding healthcare pricing, waste, incentives, and alternatives.

11. Health Rosetta - Tom Emerick

Industry profile describing his leadership of benefits at Walmart, prior roles at BP and Burger King, and employer-led healthcare purchasing strategies.

Important legal and compliance note

This playbook is educational and is not legal, tax, accounting, actuarial, or medical advice. CareerSource CLM should confirm its plan classification and final legal, procurement, compliance, and fiduciary requirements with qualified counsel and compliance advisers before implementation.

Prepared July 2026. Public requirements and guidance can change and should be reconfirmed during feasibility, procurement, and implementation.

WHY CBG EXISTS

THE ORIGIN STORY

The answer was hiding in plain sight: employers.

“The system isn’t going to fix itself.”

2020

That was the moment everything changed.

In 2020, while the world was shutting down, Mark Fox was watching something that made him sick.

Not from COVID. From what came after it.

Mark had spent years in the benefits industry. He knew how the game worked. Carriers set the premiums. Brokers shopped the renewals. Employers paid whatever they were handed. And every year, the number went up — and nobody could explain why.

Mark was part of that system. Every time a client's premiums increased, his commission check grew with it. He wasn't doing anything wrong. He was doing exactly what the industry expected.

Then COVID hit. And Mark lost a family member.

When medical bills arrived, he did what most families don't — he read them. Line by line. And what he found was infuriating. Charges for things that never happened. Procedures billed at severity levels that didn't match what actually occurred. Hospitals drowning in patients, and still finding time to add line items that didn't belong.

People were dying. And some of the biggest names in healthcare were treating it like a revenue event.

That was the moment everything changed.

"He read them. Line by line."

CHARGES FOR THINGS THAT NEVER HAPPENED.

The incentives were completely backwards.

> Every player — the carriers, the hospitals, the PBMs, even most brokers — got paid more when costs went up. Nobody had a financial reason to make healthcare cheaper.

Mark stepped back and looked at the entire system with fresh eyes — not as a broker trying to close a deal, but as someone who had just watched the machine grind through his own family. What he saw was a system perfectly designed to produce exactly the results it was producing. Every player — the carriers, the hospitals, the PBMs, even most brokers — got paid more when costs went up. Nobody had a financial reason to make healthcare cheaper. The incentives were completely backwards.

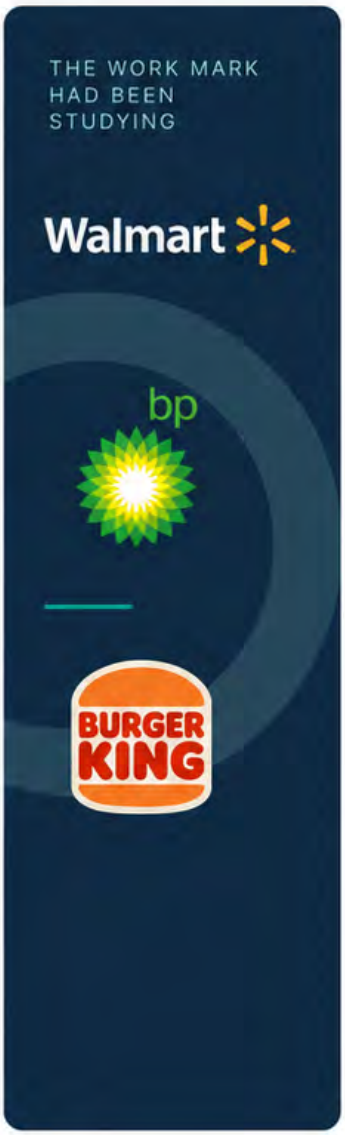
But then he asked a different question.

? **Who actually holds the power here?**

The answer was hiding in plain sight: employers.

Employers fund the entire system. Without their premium dollars, the machine stops. That meant employers weren't victims of the healthcare crisis — they were unknowingly financing it. And if they could be shown how to spend differently, the whole equation could change.

They lived inside Fortune 500 boardrooms.



Mark had been studying the work of Tom Emerick — the consultant hired by Walmart, British Petroleum, and Burger King to tear apart their health plans and find every dollar of waste hidden inside them. Tom didn't negotiate discounts off inflated prices. He rewrote the contracts. He changed who got paid and how. He realigned the financial incentives so that the health and healthcare industry only made money when it actually performed. The result? Walmart saved over a billion dollars.

But those strategies had never been built for a company with 100 to 1500 employees. They lived inside Fortune 500 boardrooms, locked behind contracts and consultants most mid-sized employers never have access to.

Mark founded CBG to change that.

The mission was simple and completely non-negotiable: bring the same strategies that protected Walmart's workforce down to the employers who needed it most — the ones facing 20%, 30%, and 40% renewal increases with no roadmap and no real advocate in their corner.

100 TO 1,500 EMPLOYEES

Those strategies had never been built for a company with 100 to 1500 employees.

04 / THE PROOF

The theory was tested almost immediately.

42%
PREMIUM INCREASE AT RENEWAL

30%
FIRST-YEAR DROP IN TOTAL HEALTHCARE SPEND

~70%
SWING FROM WHERE THE EMPLOYER WAS HEADED

A Florida manufacturer was staring down a 42% premium increase at renewal. Four employees had generated between $200,000 and $500,000 each in claims over the prior year. The carrier looked at those numbers and handed the employer a bill. Take it or leave it.

CBG took a different approach. Instead of shopping for a better discount off the same broken system, CBG deployed active risk management — Walmart-style strategies built to address the actual claims, intercept future risk, and give those employees access to better care at a fraction of the cost.

Within the first year, that manufacturer's total healthcare spend dropped by 30%. They didn't absorb the 42% increase. They went the other direction entirely — a swing of roughly 70% from where they were headed.

More importantly, they didn't have to reduce their workforce. They didn't have to freeze payroll raises. They got to take care of their people because someone finally showed them how to take control of their plan.

That's what CBG does.

Not for Walmart. For the employer nobody else is building this for.

For the employer with 100 to 1,500 employees who deserves the same intelligence, the same contracts, and the same results - without needing a billion-dollar budget to get there.

But employers who decide to stop accepting renewals as a strategy and start managing healthcare like the business expense it actually is — those employers change the equation for their company, their employees, and their bottom line.

"The system isn't going to fix itself."

THE INCENTIVES WON'T CHANGE ON THEIR OWN.

CBG exists
for that employer.

A Division of: MITIGATE+ PARTNERS

Prepared for CareerSource Citrus Levy Marion

Take Back Control of Your Healthcare Spend

A practical guide to the five pillars of a high-quality, well-run, custom self-insured group health plan.

> **“The healthcare system is not broken. It is producing the results its incentives were designed to produce.”**
>
> The opportunity for employers is not to complain about the system harder. The opportunity is to change the incentives, own the data, buy care better, and actively manage the plan.

Why this guide	What it covers	How to use it
A simple framework that employers can use to evaluate self-insured plan strategies without getting buried in insurance jargon.	Five practical pillars: incentives, data, budget protection, smarter purchasing, and better employee experience.	Use these pillars to evaluate every response in your future RFP and to spot strategies that are genuinely aligned with the employer.

CBG helps employers build smarter health plans, remove waste, improve access to care, and create more predictable healthcare spend.

INTRODUCTION

Why Employers Need a Better Framework

CareerSource Citrus Levy Marion is evaluating self-insurance at the right level: not just as a funding decision, but as an opportunity to build a better health plan.

Self-funding by itself does not fix healthcare. A strong self-insured plan works because the employer changes the rules that drive cost, quality, and accountability.

This guide is built around five pillars that matter most. Each one reflects the same principle: employers are not powerless buyers. They finance the system, which means they can demand better incentives, better data, better purchasing, and better results.

17-18%

Nearly 1 in 5 dollars

of the U.S. economy goes to healthcare.
Source: CMS National Health Expenditure Accounts.

Top 5% ≈ half of spend

A small share of people

accounts for a large share of total spend.
Source: AHRQ Medical Expenditure Panel Survey.

$25,000+

Employer family coverage

now costs more than $25,000 per year on average.
Source: KFF Employer Health Benefits Survey.

Ideas in this guide are informed by the work of **Marshall Allen, Al Lewis, Dave Chase, Tom Emerick,** and **Dr. Marty Makary**.

The Five Pillars at a Glance

1. Align the Incentives	Work only with partners whose compensation and structure support lower costs, better care, and employer control.
2. Own the Data and the Decisions	Use claims, pharmacy, and contract data to see where the money is going and what should change next.
3. Protect the Budget and Control the Big Claims	Use smart stop-loss protection and proactive management to control the small number of claims that drive most spend.
4. Buy Healthcare Better	Treat networks as access tools, not the whole strategy. Use better purchasing methods and remove unnecessary middle layers.
5. Make the Plan Better for Employees	Build a plan employees can actually use, trust, and benefit from - including CBG's proprietary Free and Clear Plan structure for eligible care pathways.

PILLAR 1

Align the Incentives

Healthcare costs often continue rising because too many organizations get paid more when costs go up. A high-quality plan starts by changing that equation.

What excellence looks like

- Advisor and partner compensation is transparent, fully disclosed, and aligned with the employer's goals - not with rising premiums or rising drug spend.
- The employer can clearly see who gets paid, how they get paid, and whether any indirect revenue, spread, rebate, or override exists.
- Strategy is separated from product placement so the employer receives independent guidance rather than a sales-driven recommendation.
- Partners are accountable for reducing waste, improving care access, and protecting employee experience - not just renewing the plan every year.

What to look for in an RFP response

- Clear disclosure of all compensation, direct and indirect, including broker, consultant, TPA, PBM, and pharmacy-related revenue streams.
- An explanation of how the advisor remains aligned with the employer if costs rise, stop-loss renewals increase, or the plan design changes.
- Evidence that the strategy does not depend on hidden spreads, commissions tied to premium growth, or revenue-sharing arrangements.
- A governance model showing how the employer retains oversight rather than delegating control to a carrier-controlled ecosystem.

CBG point of view

CBG exists to sit on the employer's side of the table. The goal is to align incentives with the employer, not with premium growth or middle-layer revenue.

Key takeaway: If the people around the plan benefit when costs rise, the employer should not expect lower costs, better care, or long-term control.

PILLAR 2

Own the Data and the Decisions

You cannot manage what you cannot see. Employers need real visibility into where the money is going and the freedom to act on what the data shows.

What excellence looks like

- The employer owns or can fully access claims, pharmacy, and utilization data in a usable format.
- Reporting is regular, understandable, and action-oriented - not just a stack of disconnected spreadsheets.
- Contracts preserve audit rights, data portability, and the ability to change vendors or strategies when better options become available.
- Leadership uses the data to make plan decisions, not just to explain last year's renewal.

What to look for in an RFP response

- Specific reporting examples that show claim drivers, pharmacy trend, high-cost claim categories, utilization patterns, and opportunities for intervention.
- Raw or near-raw data access, audit rights, and clear language about who owns the data and what happens if the relationship ends.
- A practical cadence for plan review - typically quarterly - with clear responsibility for analysis and decision support.
- Evidence that the proposed partners help the employer make decisions instead of simply administering what already exists.

CBG point of view

CBG's model is data-driven by design: let the data reveal where the waste is, then build the strategy around those findings.

Key takeaway: Owning the data does not just create transparency. It creates leverage, speed, and the ability to change the plan before costs spin further out of control.

PILLAR 3

Protect the Budget and Control the Big Claims

Self-insurance should not mean uncontrolled risk. It should mean a better balance of protection, predictability, and proactive intervention.

What excellence looks like

- The plan uses smart stop-loss protection - including specific and aggregate coverage - to cap downside risk and protect cash flow.
- Leadership understands the plan's maximum annual exposure, funding rhythm, and worst-case scenario before making a decision.
- The strategy actively focuses on the relatively small number of claims and members that drive a disproportionate share of total spend.
- Support is proactive: high-cost or high-risk situations are identified early and routed toward better options before they become much more expensive.

What to look for in an RFP response

- A clear explanation of specific stop-loss, aggregate stop-loss, maximum employer exposure, and any accommodation or advance features.
- A practical plan for identifying and managing high-cost claims, specialty drug spend, planned procedures, and other major cost drivers.
- Evidence that the proposed approach is designed for predictable renewals through active management, not just annual rate negotiation.
- A funding model that helps the employer understand cash-flow needs instead of learning those lessons after implementation.

CBG point of view

This is where discipline matters. A strong plan protects the downside and then actively helps the employees who need the most care.

Key takeaway: Employers do not need to solve every healthcare problem at once. They need to protect the budget and focus on the small share of claims that move the numbers the most.

PILLAR 4

Buy Healthcare Better

A network can help employees find providers, but a network by itself is not a cost-containment strategy. Employers need better purchasing methods, not just a bigger discount sticker.

What excellence looks like

- The plan uses multiple ways to buy care better, including direct provider relationships, bundled arrangements, transparent pharmacy purchasing, and carefully selected independent partners.
- National networks are treated as access tools when needed, while actual payment strategy is driven by value, transparency, and measurable results.
- The employer is not trapped inside a vertically integrated ecosystem that makes money at every layer while limiting choice and visibility.
- The strategy removes unnecessary middle layers where they do not improve care, speed, quality, or economics.

What to look for in an RFP response

- Evidence of alternative purchasing pathways beyond the default network discount model.
- A pharmacy strategy that addresses transparency, specialty drugs, and whether pricing is aligned with the employer's interests.
- An explanation of how the proposed structure avoids unnecessary dependence on vertically integrated entities whose incentives may not favor lower costs.
- Examples of how the strategy improves the way the employer purchases surgeries, imaging, pharmacy, specialty care, or other major spending categories.

CBG point of view

CBG's philosophy is simple: when possible, connect the patient and the provider more directly, strengthen accountability, and stop paying for avoidable friction.

Key takeaway: The goal is not to buy more healthcare. The goal is to buy the right healthcare, at the right price, with the fewest unnecessary layers in between.

PILLAR 5

Make the Plan Better for Employees

A plan only works when employees understand it, trust it, and know how to use it. Better cost control should create a better experience, not just more employee disruption.

What excellence looks like

- Employees receive clear guidance, practical education, and a visible support path before they make high-cost healthcare decisions.
- The plan improves access to high-value care while reducing unnecessary out-of-pocket costs whenever a better pathway is available.
- HR is supported instead of overwhelmed, and the communication strategy extends beyond open enrollment into the rest of the year.
- The Free and Clear Plan - CBG's proprietary structure - helps eligible employees access lower-cost, high-quality care pathways with a simpler, more guided experience.

What to look for in an RFP response

- A real communication and employee-engagement plan, not just a benefit summary handed out at enrollment.
- Clear explanation of who helps employees before a surgery, scan, infusion, or specialty drug decision becomes a major claim.
- Evidence that the strategy can improve benefits and employee experience while still reducing waste for the employer.
- A structure that shows how the Free and Clear Plan or similar care-navigation approach will be explained, supported, and measured.

CBG point of view

This is one of CBG's defining beliefs: lower employer cost and better employee experience are not opposites when the plan is built correctly.

Key takeaway: A strong health plan does not win by shifting more cost to employees. It wins by helping employees access better pathways, earlier support, and a simpler experience.

FINAL PAGE

Use These Five Pillars to Evaluate Every Response in Your Future RFP

The most important question is not whether a proposal sounds sophisticated. The most important question is whether it is aligned with the employer, grounded in data, protective of the budget, smarter in how it buys care, and better for employees.

- ✓ Does the response clearly align compensation and incentives with the employer's goals?
- ✓ Does the employer own the data, retain decision-making power, and receive practical reporting?
- ✓ Does the strategy protect the budget and actively address the small number of claims that drive most spend?
- ✓ Does the response show a better way to purchase care and remove unnecessary middle layers?
- ✓ Does the plan improve the employee experience and explain how the Free and Clear Plan will work?

Further reading and influences

- Marshall Allen - Never Pay the First Bill
- Al Lewis - employer health plan critique and measurement
- Dave Chase - employer-driven healthcare purchasing
- Tom Emerick - employer-led plan design and direct contracting
- Dr. Marty Makary - The Price We Pay

Selected supporting sources

- Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Accounts
- Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey
- Kaiser Family Foundation (KFF), Employer Health Benefits Survey
- CBG CareerSource Self-Insurance RFI Playbook
- CBG Origin Story and internal strategy materials

CBG's proprietary Free and Clear Plan is designed to help eligible employees access higher-value care pathways with better support and lower out-of-pocket exposure while helping the employer reduce unnecessary spend.