McALLEN
PUBLIC UTILITY

NOTICE OF A JOINT MEETING TO BE HELD BY THE MCALLEN PUBLIC UTILITY BOARD OF TRUSTEES AND MCALLEN BOARD OF COMMISSIONERS

DATE: **Monday, June 27, 2022**

TIME: **4:00 PM**

PLACE: **McAllen City Hall**
Commission Chambers - 3rd Floor
1300 Houston Avenue
McAllen, Texas 78501

VIRTUAL: Zoom.US/Join
https://us02web.zoom.us/j/5087553077?pwd=TjduYjR4U2l3cWU1NjlsZzlsM2hJUT09

Meeting ID: 508 755 3077
Passcode: 878576

Members of the public that wish to listen to the meeting can log in to the virtual Zoom meeting or dial 1 346 248 7799 US (Houston) Meeting ID: 508 755 3077 Passcode: 878576.

JOINT MEETING WITH THE MCALLEN BOARD OF COMMISSIONERS

CALL TO ORDER

1) Discussion and Possible Action regarding recommended changes to the City of McAllen Health Plan for 2022-23.

ADJOURNMENT

CERTIFICATION

I, the Undersigned Authority, do hereby certify that the attached agenda of the meeting of the McAllen Public Utility Board of Trustees is a true and correct copy and that I posted a true and correct copy of said notice on the bulletin board in the Municipal Building, a place convenient and readily accessible to the general public at all times, and said Notice was posted on June 24, 2022 at 3:00 PM and will remain so posted continuously for at least 72 hours preceding the scheduled time of said meeting in accordance with Chapter 551 of the Texas Government Code.

Nyla L. Flatau, TRMC/CMC, CPM
Utility Board Secretary

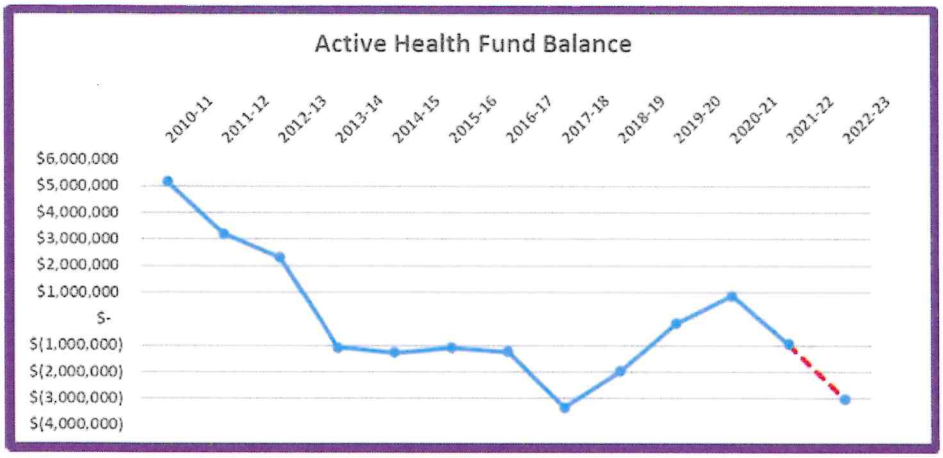
2022-23 HEALTH PLAN RECOMMENDATIONS

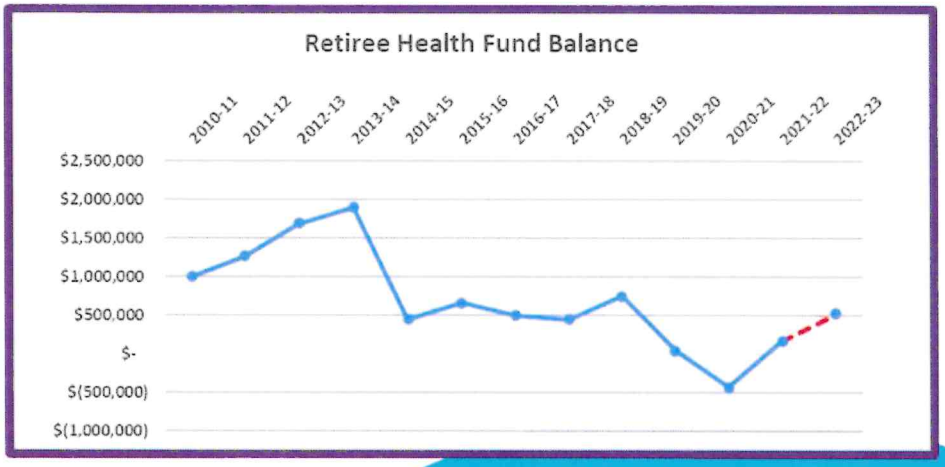
Presented to City Commission & Public Utility Board
June 2022

Current 2021-22 Health Plan Information

FULL PREMIUMS	Base Plan	Buy Up Plan	Retiree Over 65
Employee Only	$404.00	$458.00	$404.00
Employee Plus Spouse	$888.00	$942.00	$888.00
Employee Plus Child	$814.00	$860.00	$814.00
Employee Plus Family	$942.00	$1,076.00	$942.00
ENROLLMENT	Base Plan	Buy Up Plan	Retiree Over 65
Employee Only	1074	111	12
Employee Plus Spouse	103	32	9
Employee Plus Child	195	37	0
Employee Plus Family	261	74	0
IN-NETWORK	Base Plan	Buy Up Plan	Retiree Over 65
Covered Services Coshare	80/20	80/20	80/20
Deductible - Individual	$1,500	$850	$0
Deductible - Family	$3,000	$1,700	$0
Out of Pocket Max - Individual	$5,000	$2,850	$3,500
Out of Pocket Max - Family	$10,000	$4,000	$7,000
Primary Care Visit - Tier 1	$20	$20	$0
Primary Care Visit	$35	$35	$0
Specialist Visit - Tier 1	$30	$30	$0
Specialist Visit	$45	$45	$0
Virtual Provider	$0.00	$0.00	$0.00
Emergency Room	$150 + 20%	$150 + 20%	$150 + 20%
Urgent Care	20% Coinsurance	20% Coinsurance	20% Coinsurance
Preventative Care	Covered/No Charge	Covered/No Charge	Covered/No Charge
OUT OF NETWORK	Base Plan	Buy Up Plan	Retiree Over 65
Covered Services Coshare	50%	50%	50%
Deductible - Individual	$2,500	$1,700	$1,000
Deductible - Family	$4,000	$3,400	$2,000
Out of Pocket Max - Individual	$6,000	$5,000	$5,000
Out of Pocket Max - Family	$Unlimited	$Unlimited	$Unlimited
Primary Care Visit	50% Coinsurance	50% Coinsurance	50% Coinsurance
Specialist Visit	50% Coinsurance	50% Coinsurance	50% Coinsurance
Preventative Care	Not Covered	Not Covered	Not Covered
PHARMACY	Base Plan	Buy Up Plan	Retiree Over 65
Tier 1 Prescriptions	$10 Copay	$10 Copay	$10 Copay
Tier 2 Prescriptions	$40 Copay	$40 Copay	$40 Copay
Tier 3 Prescriptions	$60 Copay	$60 Copay	$60 Copay
Tier 4 Prescriptions	$125 Copay	$125 Copay	$125 Copay
Out of Network Prescriptions	20% Coinsurance	20% Coinsurance	20% Coinsurance

Health Fund Projections FY 22-23





LEADING COST FACTORS

- *COVID Related Claim Expenses $2,044,178*
- *Delayed initial/preventative care*
- *Execution of previously postponed non-emergency procedures*
- *Inflation*
- *Adverse selection in Base vs. Buy Up Plan*
- *Implementation of legislation (CAA/NSA Eff 10/01/22)*

FY 2022-23 Projections	Active Fund	Retiree Fund
Beginning Fund Balance *21-22 Budget Adjustment ($954,292)*	$1,114	$169,894
Revenues	$13,213,985	$1,655,507
Health & Pharmacy Claims	$13,967,102	$1,222,000
FIxed Costs	$1,699,944	$86,494
Administrative Expense	$577,480	N/A
Ending Fund Balance	($3,029,427)	$516,907

Projected Savings
$1,999,759

Plan Change Recommendations

Recommendations include the elimination of the Buy Up Plan as well as a recommendation that the Base Plan type be modified from a PPO Network to an EPO Network. Where as PPO Networks have out-of-network benefits, EPO's do not have out-of-network benefits. Exclusion of out of network coverage in an EPO is based on care received in a setting where the patient was in control. Emergency care is treated as in-patient when the patient did not control site of care.

IN-NETWORK	Base Plan	Buy Up Plan	Retiree Over 65
Deductible - Individual	$1,500 to $2,000	PLAN ELIMINATED	No Change
Deductible - Family	$3,000 to $4,000	PLAN ELIMINATED	No Change
Out of Pocket Max - Individual	$5,000 to $6,000	PLAN ELIMINATED	$3,500 to $4,000
Out of Pocket Max - Family	$10,000 to $12,000	PLAN ELIMINATED	$7,000 to $8,000
Primary Care Visit	$35 to $45	PLAN ELIMINATED	No Change
Specialist Visit	$45 to $55	PLAN ELIMINATED	No Change
Virtual Visit	$0 to $10	PLAN ELIMINATED	$0 to $10
Emergency Room	$150 + 20% Coinsurance to $250 + DED	PLAN ELIMINATED	$150 + 20% Coinsurance to $250 + DED
Urgent Care	20% Coinsurance to $50 + 20% Coinsurance	PLAN ELIMINATED	20% Coinsurance to $50 + 20% Coinsurance
OUT OF NETWORK	**Base Plan**	**Buy Up Plan**	**Retiree Over 65**
Covered Services Coshare	50% to Not Covered	PLAN ELIMINATED	No Change
Deductible - Individual	$2,500 to Not Covered	PLAN ELIMINATED	$1,000 to $3,000
Deductible - Family	$4,000 to Not Covered	PLAN ELIMINATED	$2,000 to $6,000
Out of Pocket Max - Individual	$6,000 to Not Covered	PLAN ELIMINATED	$5,000 to $10,000
Out of Pocket Max - Family	Unlimited to Not Covered	PLAN ELIMINATED	No Change
Primary Care Visit	50% Coinsurance to Not Covered	PLAN ELIMINATED	No Change
Specialist Visit	50% Coinsurance to Not Covered	PLAN ELIMINATED	No Change
PHARMACY	**Base Plan**	**Buy Up Plan**	**Retiree Over 65**
Tier 1 Prescriptions	$10 Copay to $20 Copay	PLAN ELIMINATED	$10 Copay to $20 Copay
Tier 2 Prescriptions	$40 Copay to $50 Copay	PLAN ELIMINATED	$40 Copay to $50 Copay
Tier 3 Prescriptions	$60 Copay to $70 Copay	PLAN ELIMINATED	$60 Copay to $70 Copay
Tier 4 Prescriptions	$125 Copay to $135 Copay	PLAN ELIMINATED	$125 Copay to $135 Copay

** The Diabetes Health Plan benefit (no copays for visit/Rx) remains unchanged for eligible members.*

PREMIUM RECOMMENDATION

Projected Savings
$395,400

Strategy includes focus on attempting to maintain as close to current percentage of employee and dependent subsidy while still improving overall revenues needed to fund the plan.

SUBSIDY

Employee Coverage maintains 95% subsidy.
Dependent Coverage moves from 50% to 49% subsidy.

NET IMPACT BY ENROLLMENT

EMPLOYEES / BASE PLAN	$96,588
EMPLOYEES / BUY UP PLAN	($240,480)
CITY SUBSIDY	$485,532
RETIREES/COBRA	$20,568
AGENCIES	$33,192

BASE PLAN	TIER	CURRENT	PROPOSED
EMPLOYEE CONTRIBUTION (PREMIUM)	*EE ONLY*	$20	$20
	EE PLUS SPOUSE	$262	$268
	EE PLUS CHILD	$225	$230
	EE PLUS FAMILY	$289	$294
CITY CONTRIBUTION (SUBSIDY)	*EE ONLY*	$384	$410
	EE PLUS SPOUSE	$626	$652
	EE PLUS CHILD	$589	$614
	EE PLUS FAMILY	$653	$678
TOTAL PREMIUM	*EE ONLY*	$404	$430
	EE PLUS SPOUSE	$888	$920
	EE PLUS CHILD	$814	$844
	EE PLUS FAMILY	$942	$972

** Agencies of the City are charged the full premium rates and they determine employee portion on their own.*

** Retirees are subject to full premium rates.*

** COBRA Participants are subject to full premium rates plus 2% administration fees.*

Projected Savings
$300,000

NAVIGUARD RECOMMENDATION

The City currently uses a program called "**Shared Savings**" through United Healthcare. The Shared Savings Program provides access to discounts from non-Network Physicians who participate in the program. Used to pay claims, this program reduces eligible expenses and is built off a **percentage to Medicare rates**. In doing so, patient liability is limited to the calculated contracted rate paid to the provider versus open balance billing. Therefore the plan and the member save. There are fees associated with this program - 29% of savings.

Naviguard is a replacement program offered through United Healthcare. Under this program, UHC uses **reference based pricing** which drives an average savings of 72% of these out-of-network billed charges. The savings outpace that of the Shared Savings Program. Additionally, fees are fixed at a Per Employer Per Month rate.

Financial Savings

The new methodology negotiates claims stronger. Taking a look at the $956,439 saved in 2020-21 through Shared Savings, under Naviguard **we would have seen an additional $243,699 in claims savings**.

Under Shared Savings, were were seeing an average of $10.69 PEPM under the 29% shared savings fee structure. Though we could average the financials historically, the actuals were not fixed and varied month to month based on claims processing, making it hard to truly project financially.

With Naviguard, the **fees are fixed at $2.50 PEPM**. Naviguard will cost approximately $5000 per month, while under Shared Savings our lowest month of fees in last 18 months was $12,132 and our highest month hit $68,812. This equates to approximately **$187,419 in savings annually.**

Advocacy

Naviguard provides members with 1-on-1 support to navigated the complexities of Out-of-Network billing and guard patients from surprise bills / delayed bills from these Providers.

- A dedicated advisor works with member throughout the process.
- The dedicated advisor reaches out to Provider on members behalf to negotiate.
- Online patient portal allows patients to interact when it's most convenient.
- Outcomes of provider negotiations are clearly communicated, and member prepared for next steps.
- Personalized guidance helps members stay in-network and avoid out-of-network services.

Prep for NSA

Effective 10/01/22, our plan must comply with the No Surprises Act (NSA) which is aimed at protecting health plan members from surprise medical bills from Out-of-Network (OON) Providers and facilitating payment dispute resolutions among providers and insurers/health plans. NSA applies to covered OON benefits for certain emergency situations, air ambulance and when an OON provider is providing services at a network facility. Naviguard helps support this compliance by offering a clear approach to managing OON benefits and preventing the Independent Dispute Resolution (IDR) process under NSA. The evaluation of network negotiation history, analyzing claims and member advocacy are inherent under NSA and built into Naviguard's program.

STOP LOSS RECOMMENDATION

Projected Savings
$225,687

Individual Stop Loss is an insurance policy the City buys to cover claims expenses when an individual's claim exceeds a certain threshold. It removes large potential liability from the City for a set fixed rate premium. Evaluating our claims history and the renewal premium rates for 2022-23, it is recommended that we consider increasing our stop loss threshold to save on current fixed costs.

Two options are presented, an increase from $250K to $275K, as well as $300K *(recommended)*.

ISL THRESHOLDS	CURRENT $250k	OPTION 1 $275k	OPTION 2 $300K RECOMMENDED
Annual Stop Loss Premium Based on 1925 Subscribers	$1,513,512	$1,384,845	$1,287,825
Savings from Threshold Change	N/A	$129,000	$225,687
Savings Breakeven Claim Count		5	5
Total Claims Hitting Threshold Within Last 5 Years	14 *(2.8 Average)*	13 *(2.6 Average)*	12 *(2.4 Average)*
2020-21 Claims Hitting Threshold	4	2	1
2020-21 Recalculated Additional Claims Payments		$60,000	$88,000
2020-21 Recalculated Net Savings		$69,000	$137,687

Projected Savings
$4,876

AGENCY CONTRACT RECOMMENDATION

RECOMMENDATION #1

Amend contract Agency Administration Fee from $75 PEPM to an amount equal to the fixed TPA cost plus and additional 15% to cover overhead expenses. Administrative Fee must be at least $5 above TPA fixed cost minimally. Where calculated percentage of TPA fixed cost is lower than $5, the $5 flat fee will be utilized.

The City of McAllen extends benefits to employees of seven agencies within the McAllen area. Current terms of contract include an administrative fee charged to the Agencies of $75 per employee per month to cover our administrative overhead ($1000 average) as well as the monthly Third Party Administrator (TPA) Fixed Cost. Current Administrative Fees are not providing for expenses as intended.

PER EMPLOYEE PER MONTH	2021-22 CURRENT	2022-23 RENEWED	2022-23 RENEWED PLUS 15% ADMIN *Based on $250K Stoploss*	2022-23 RENEWED PLUS 15% ADMIN *Based on $300K Stoploss*
CARRIER TPA FEE	$72.18	$77.20	$77.20	$67.43
AGENCY ADMIN FEE	$75	$75	$88.78	$77.54

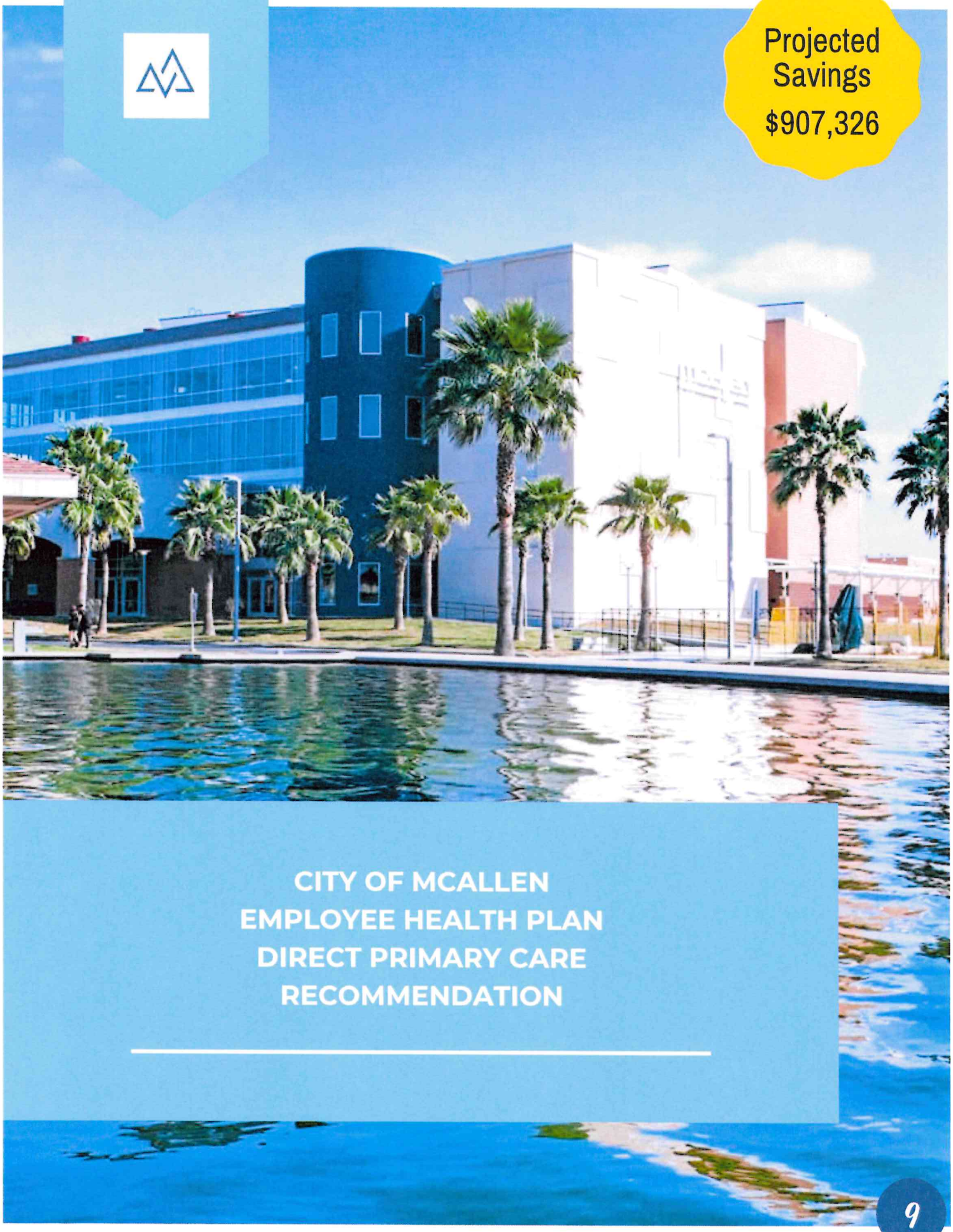
RECOMMENDATION #2

Amend contract to include language that requires all benefits eligible agency employees to reside within the Rio Grande Valley in order to be offered benefits through the City of McAllen.

During the course of the pandemic, a scenario arose that had City staff looking into capabilities to meet needs of an agency with possible remote employees from another state. It was determined that we could not ensure compliance with laws and the ability to operate with interstate/out of area employees was not feasible.

NOTE: *Another recommendation being presented for review is a primary direct care clinic. Should this recommendation be approved and include Agencies, there are additional fixed costs associated. If approved, language should be included in the amendment that also references the primary care direct fees be added into the premium costs for Agencies, whom can then cost share are their discretion with employees.*

This would be an additional $133,920 in revenue.



Projected Savings

$907,326

CITY OF MCALLEN EMPLOYEE HEALTH PLAN DIRECT PRIMARY CARE RECOMMENDATION

CHALLENGES WITHIN HEALTHCARE

1

Most Primary Care Providers have in excess of 2,500 patients under their care.

Large amounts of patients (units) make it difficult to schedule timely visits with doctors and result in long waits in the lobby upon arrival, only to be seen by someone other than the doctor themselves in most cases. Average facetime with whoever is seeing the patient is only 3-5 minutes. Very little relation is established nor education and encouragement given in this brief time.

2

Medical care is often driven by insurance and adds hurdles to care.

Pre-authorization requirements, productivity benchmarks, competing clinical guidelines and pay for performance initiatives are just a few challenges providers face when attempting to take care of their patients.

Patients must limit the visit to only one item at a time due to billing purposes. Preventative care is often delayed/avoided because what began as a free visit can turn to charged items without the patient being aware.

3

The relational holistic approach to patient care is hands off.

Very little relationship with the primary care doctor, coupled with small intervals of facetime make it hard for the doctor to truly know the patient, their lifestyle, their medical/health regimens, etc. Root causes are rarely identified and only symptoms are primarily treated in traditional healthcare.

To improve health is not to address symptoms (i.e. taking a pill to relieve pain or prevent a heart attack). It is to create a treatment plan that includes lifestyle choices that will remove the cause of the pain or the likelihood of the heart attack, perhaps preventing ongoing medication needs. Behavioral health must be a part of the whole picture for success.

4

Pricing transparency is lacking and system is set up for profits not health.

Provider profits are derived from units of care x average unit price. When a wellness program seeks to reduce units of care, the healthcare providers have to offset lost income by increasing average unit price. Thus cycle continues of high claims expenses.

Meanwhile patients don't understand what they are liable for, often surprised at unexpected medical bills. Often, that causes patients to avoid getting care altogether, later leading to higher dollar claims.

TRANSFORM

Literally means to change form...

Over the past decade, we have faced funding shortfalls. We have tried to fill the funding gaps through traditional design changes as well as programs that were aimed at moving the needle on actual health outcomes of our members. While most of these traditional changes and programs were deemed successful within themselves, they have not been transformative within the population as a whole. They have helped limited populations (though they were among the sickest) and they have not fostered any sweeping overhaul of how healthcare is delivered and received.

The old saying goes.....

the definition of insanity is doing the same thing over and over again and expecting a different result.

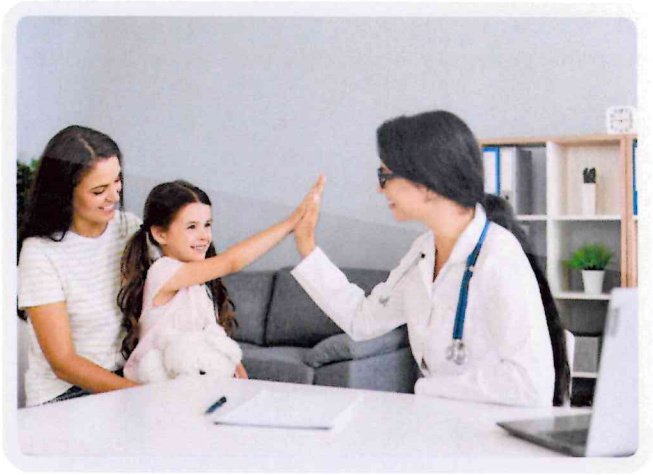
If we are **to truly transform** our health plan population to as a means to improve funding (among other benefits), without plan design changes that may cost shift to members, then we **have to be willing to change**.

Desired transformation is birthed from intentional goals, such as ours:

- **Improve health of plan membership.**
- **Improve satisfaction of plan membership.**
- **Meet funding needs for annual expenses.**
- **Build a safety reserve for catastrophic/unanticipated claims.**
- **Minimize design change that only restricts benefit and cost shifts.**
- **Utilize health plan benefits as an employee retention asset.**

Transforming McAllen

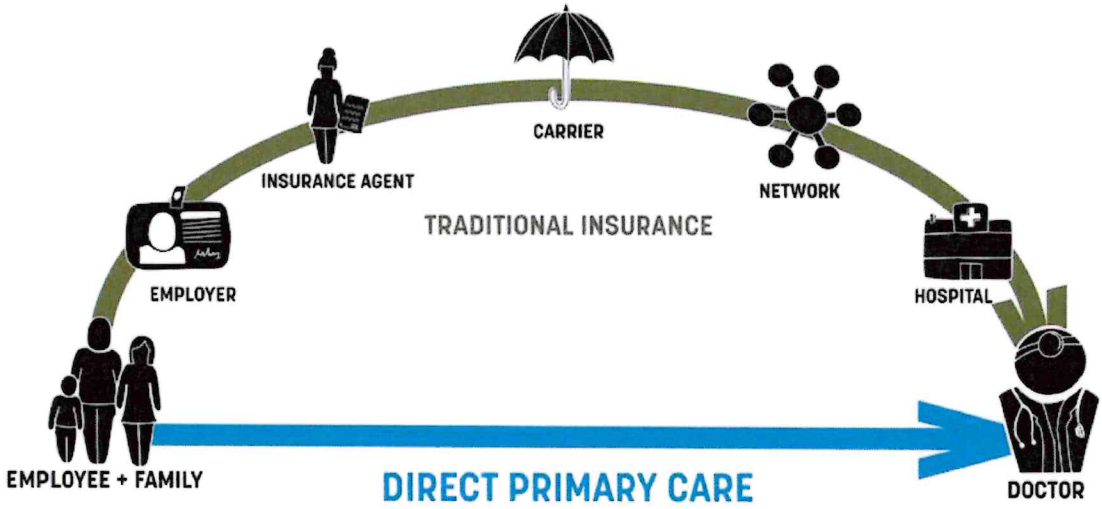
DIRECT PRIMARY CARE RECOMMENDATION

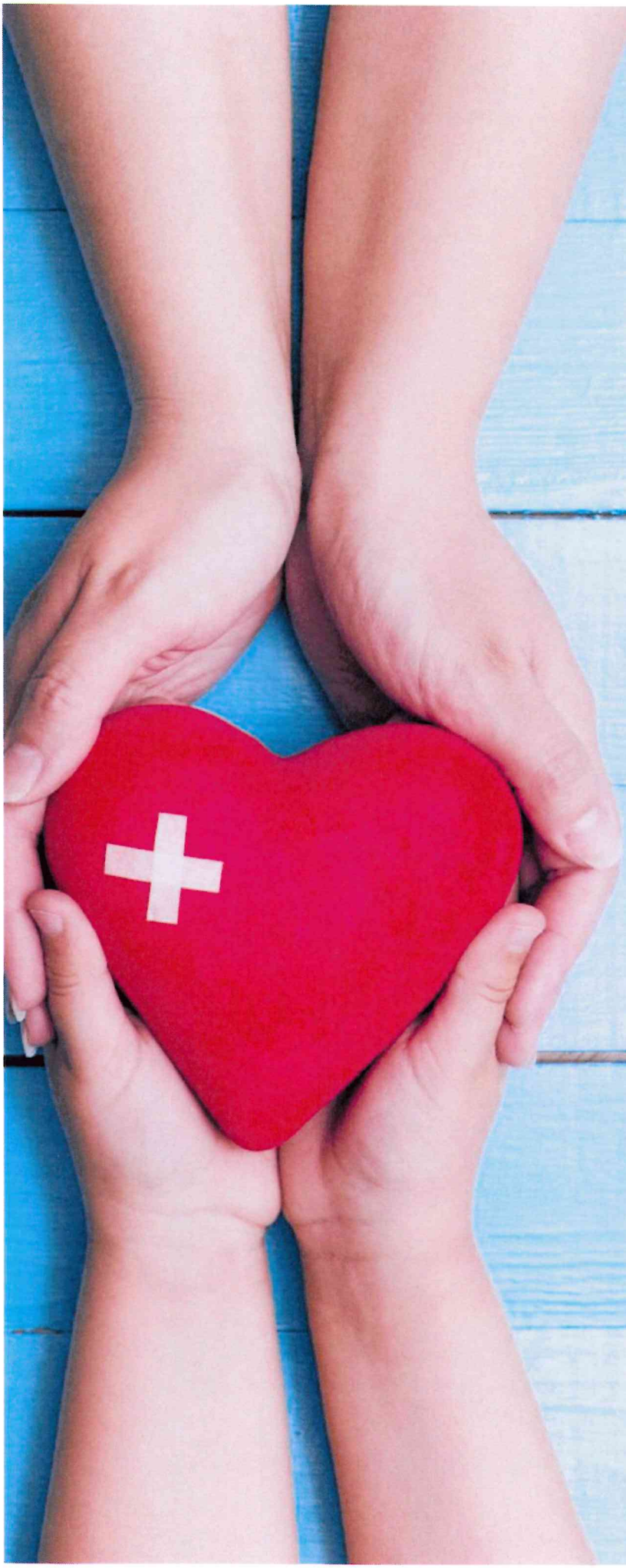


Offsetting the problems mentioned within today's traditional healthcare, Direct Primary Care (DPC) is a progressive approach that **brings healthcare back to its roots** - caring for the patient and **driving health outcomes**.

Direct Primary Care (DPC), is a simplified health care model that **removes insurance from primary care** and replaces the fee-for-service as the means by which today's healthcare industry transacts. For a **set monthly fee**, patients have **unrestricted access** to their primary care physician - a person who they know and knows them.

Patients, having their doctor's cell number, **can engage through email, text, phone calls, virtual visits and in-person visits as they choose**. Office visits are not only easy to get same day, but **appointments start at the actual time for which you scheduled**. All routine primary care by the physician in house are at **no additional cost**.





Patient load is capped for a doctor at **no more than 800 patients**, though special populations may call for a lower cap to be developed. This patient cap along with the removal of insurance claims/hurdles allows the patient quick and easy access to their physician and it solidifies relational development through **longer sessions with their physician.**

When outside referrals are needed, many times these **referral services (such as an MRI, Colonoscopy, etc.) can be completed under a discounted pricing at a third party.** This not only saves the plan, but also the members who traditionally would be subject to deductibles/copays and unknown liabilities that come after care has been received.

The model greatly **improves the doctor-patient relationship, reduces the fragmentation of patient care** and **improves the satisfaction for members.** Implementing a DPC model **reduces member out-of-pocket expense** as well as **reducing overall plan spend,** particularly through 1) Removing most primary care expenses, 2) Improving patient engagement that leads to reduced Urgent Care/ER visits, and ultimately impacting a reduction in catastrophic claims.

DIRECT PRIMARY CARE vs. TRADITIONAL PRIMARY CARE

PATIENT CARE

DPC typically care for 1/3 patient load (cap of about 800 patients). Where populations require some specialty, these caps can be reduced even further to ensure that the physician always has the time for every patient.

Each visit is much longer (typically 30-60 min) and allows for holistic care built on relationship between the primary care doctor and patient.

Average patient load per physician is 2500. Patient volume driven to support overhead staffing needed for paperwork, claims, collections, and more.

With volume, wait times increase. Time with provider is limited (usually 7 min) though they may never see their actual primary care doctor.

Long waits and unknown providers are known to motivate patients to forgo or to delay care.

COST

The monthly fee that is paid on behalf of each member gives patients access to the clinic including unlimited visits and time with their doctor.

There are no out of pocket charges for routine primary care. A handful of procedures available in house have an extra charge associated - and known to member in advance. An employer can pick up these charges at their discretion.

Primary care doctors charge a individual fee per service. Additionally chronic conditions or issues that are brought up during visit may increase cost of the single visit.

Fees are generally not known by employee up front, nor is their out of pocket - post insurance payment - amount known in advance at times causing confusion and stress by patients before, during and after care is received.

CONVENIENCE

With unrestricted access, many times no visit to the clinic is needed. A patients condition can be assessed by phone, text, email or virtual chat.

When a visit is needed or wanted, appointments begin when they are scheduled - no long wait in a waiting room. This gets patients back to their needed activities faster.

Clinics have waiting rooms filled with patients in line to be seen, and it can take days or weeks at times to get into a clinic.

Time is required by patients to take off work to travel to the clinic as well as wait to be seen.

SERVICE

When a prescription is needed, it is ran through the formulary assessment to determine if it is covered BEFORE it is sent to the pharmacy for the patient.

Referrals are either verified as in-network under insurance plan or are a negotiated price point provider and patient knows all costs up front. No guessing of out of pocket expenses for patient.

Doctors orders, referrals and prescriptions are handed off to admin staff/nurses. Referrals not always vetted against insurance network, prescriptions not vetted against insurance formulary.

This can result in back and forth communication with providers and pharmacies and delayed care/treatment.

SOCIETY OF ACTUARIES

In May 2020, The Society of Actuaries released a 98-page study on Direct Primary Care models. Some of the key notes of the study are shown here:

- Observed positive cost-related and utilization-related effects from the introduction of a DPC option in the employer's self-insured health benefits plan, including:
  - Statistically significant reduction in overall demand for health care services (-12.64%) and emergency department usage (-40.51%).
  - Lower inpatient hospital admission rate (-19.90%).
- Potential benefits from DPC may go beyond cost to include:
  - Increased access to no-cost primary care/urgent care services from same provider.
  - Employee absenteeism rate reduction
- Improved relationship with patients and quality of care resulting from such relationship.
- Increased patient compliance with preventative care / chronic condition care plan.

UNION COUNTY, NC

In 2015, Union County piloted a DPC program to improve quality and access of care to its 1,000 employees and their dependents. Results were well documented for analysis by the County.

- DPC participants incurred 23% less medical expenses than non DPC participants, yielding annual plan savings of $1.28 Million.
- DPC participants incurred 36% less in prescription expenses compared to non DPC participants, yielding plan savings of $239,000.
- DPC participants spent 46% less out-of-pocket for medical and prescription expenses compared to non-DPC participants, saving members $333,639 annually.
- DPC participants reported significant improvement to overall health since electing DPC option by nearly 3:1 margin.

LOCATIONS

Frontier McAllen
1000 West Way Ave.
McAllen, TX 78501
2ND MCALLEN LOCATION IN PROGRESS

Frontier Weslaco
555 S. International Blvd.
Weslaco, TX 78596

Frontier Harlingen
224 East Jackson
Harlingen, TX, 78550

Frontier Brownsville
222 N. EXP 77, Suite 302
Brownsville, TX, 78521

Frontier Raymondville
100 N US HWY 77, Unit K
Raymondville, TX 78580

FRONTIER DIRECT CARE

FDC is the only DPC in the state of Texas that has been issued a DHCPO license by the Texas Board of Insurance. As such, it is considered a sole source provider.

EMPLOYEE ONLY MEMBERSHIP $60 / MO	EMPLOYEE & SPOUSE (OR CHILDREN) MEMBERSHIP $120 / MO	EMPLOYEE & FAMILY MEMBERSHIP $180 / MO

COVERED AT NO COSTS TO MEMBERS

Family Medicine

- Routine PCP Visits
- Acute Illness Visits
- Annual Physical & Sports Exams
- Weight Loss Consultations
- Chronic Disease Management
- Sports Medicine

Minor Procedures

- Laceration Repairs
- Wart Removal
- Abcess Drainage
- Wound Care
- Venipuncture

Women's Health

- Annual Women's Exam
- Family Planning
- Pregnancy Testing (urine)

Basic Eye Exam

- Vision Screening
- Removal of Foreign Body

FDC is equipped to handle Fire Department physicals with initial evaluations showing extensive savings.
FDC is capable of being a frontline for worker compensation claims that don't need to be escalated.
FDC is also open to discussion of an onsite clinic.

FRONTIER DIRECT CARE

IN OFFICE PROCEDURES AT EXTRA COST

Services that come at cost are more competitive than what can be charged through the health plan. The City can choose to have employee pay these services - which most service rates are lower than their liability under the plan design - or the City can choose to pick up these expenses.

In either scenario, both employee and the City mutually save money.

Minor Procedures

- Steroid Injection $2.00
- Spirometry $7.00
- IV Hydration $3.50
- Antibiotic Injection $1.76
- B12 Injection $8.80

Men's Health

- Testosterone Injection $3.00
- STI Testing Avg $22.00
- Testosterone Blood Test $13.50

Sleep Issues

- Sleep Study $150.00

Radiology *(Out of Office)*

- X-Ray $52.50
- MRI $315
- CT $210
- Ultrasound $84.00
- Mammogram $78.70
- Bone Density $68.25
- Echiocardiogram $202.50

Lab Tests & Pathology

- Strep Test $3.30
- COVID 19 Rapid $10.00
- Flu Test $11.00
- Skin Biopsy $16.50
- Blood Test - varies

Women's Health

- Pap Smear $22.00
- STI Testing Avg $22.00
- Complete Hormone Testing $81.40

Cardiology *(Out of Office)*

- Holter Monitor $62.95
- Lexicscan Nuclear Stress Test $697.02
- Treadmill Nuclear Stress Test $515.97
- Carotid Ultrasound $193.55
- Stress Echocardiogram $320
- Arterial Doppler $105.00
- Renal Doppler $268.71

Gastroenterology *(Out of Office)*

- Consultation $150
- Colonoscopy $700
- EGD Biopsy $700

SOME CURRENT CLIENTS

VTX1
Harlingen Irrigation District
Valleywide Home Health
Freedom Insurance
Care RX Pharmacy
Logos Community Church

Frontier monitors their clinic membership counts very thoroughly.

As a clinic nears capacity of members, FDC begins to implement another launch for a new clinic.

Turnaround time to open a new clinic is two months and the process is extremely streamlined.

There is a waiting list for physicians looking to join Frontier.

FEES & SAVINGS PROJECTIONS

Enrollment Eligibility	Annual Membership Fees	60% Adoption Savings Projections	Fees Collected from Agencies	Net Savings
HEALTH PLAN MEMBERS EE & DEP NON RETIREE OVER 65	$2,126,880	$2,900,286	$133,920	$907,326

Net Savings In First Year $907,326

Net Savings Over Five Years $9 Million

Recommendation presented includes implementation of Frontier membership for all health plan covered members (including dependents) except Retirees Over 65.

A conservative adoption rate of 60% was utilized in this analysis. Local trend and historical adoption of the City's preferred clinic indicate that we would likely see above 75% adoption if program is effectively rolled out.

Financial Retroactive Analysis

2020-2021 Claims Re-evaluated

Savings

	20-21 CLAIMS COSTS	20-21 CLAIMS COSTS w/FDC	GROSS SAVINGS
Physician Visits	$2,805,414	$1,229,311	$1,576,103
Facility Visits	$8,290,356	$6,062,704	$2,227,652
Pharmacy	$4,116,113	$3,498,696	$617,417
TOTALS	**$15,211,884**	**$10,790,711**	**$4,421,172**

Fees

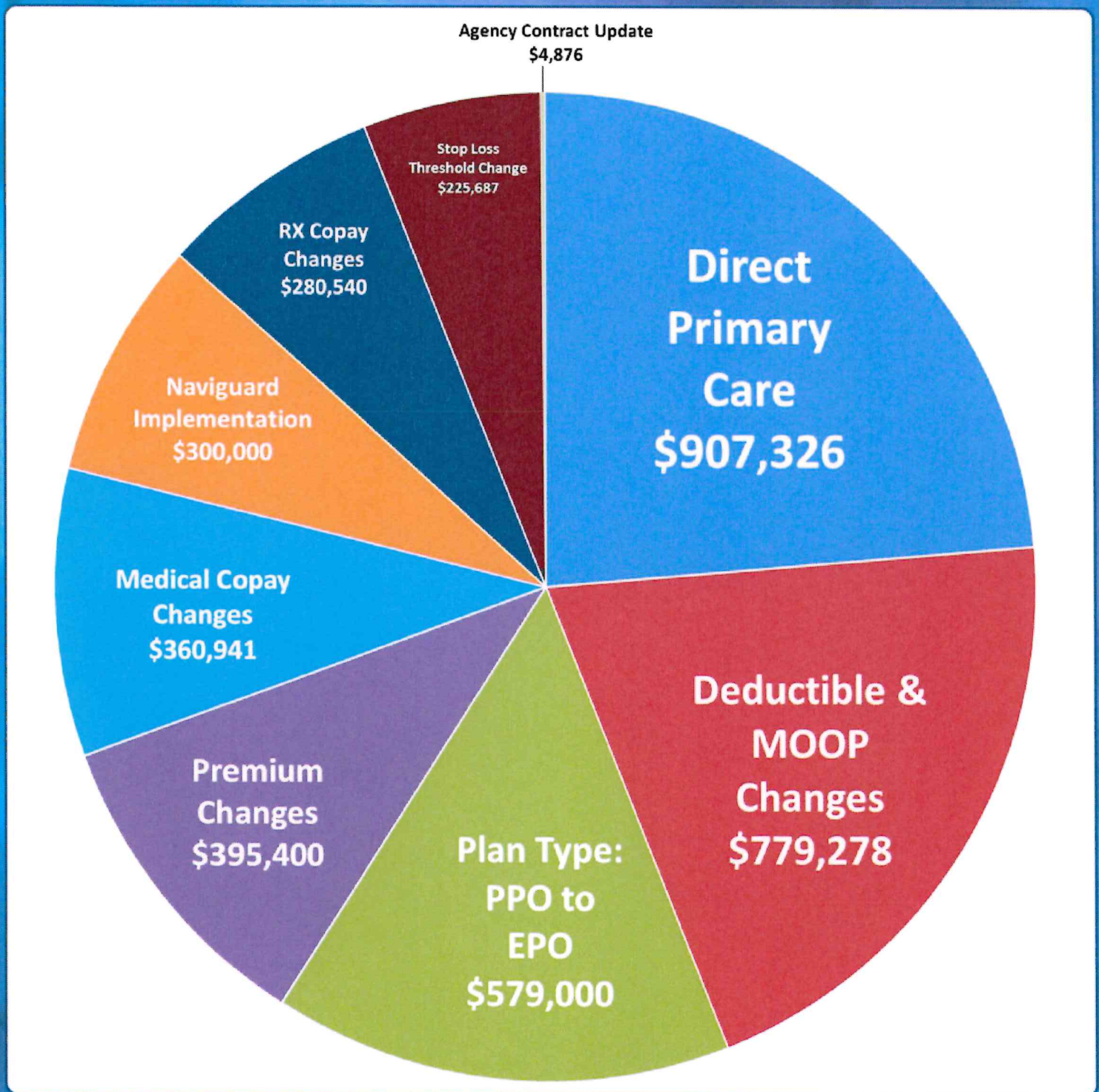
FDC Membership Fees	$2,126,880
Agency Fee Collection	($133,920)
TOTALS	**$1,992,960**

Net Savings

20-21 Claims Recalculated Savings Net of Membership Fee	**$2,428,212**

** Assumes 100% adoption, Agencies cover fees for Agency employees, City covers fees for employees and at-cost services.*

RECOMMENDATION SUMMARY



Recommendations Summary

The following items are summarized items from the 2022-23 Health Recommendations Proposal.

Projected Savings
$3,833,048

RECOMMENDATION	BASE PLAN	BUY UP PLAN	RETIREE POST 65 PLAN
Plan Type Change $579,000	PPO to EPO	ELIMINATE PLAN	No Change
Deductible/MOOP Changes $779,278	In Ded Ind: $1500 to $2000 In Ded Fam: $3000 to $4000 Out of Network No longer Covered In MOOP Ind: $5000 to $6000 In MOOP Fam: $10000 to $12000	ELIMINATE PLAN	No Change No Change Out Ded Ind: $1000 to $3000 Out Ded Fam: $2000 to $6000 In MOOP Ind: $3500 to $4000 In MOOP Fam: $7000 to $8000 Out MOOP Ind: $5000 to $10000
Medical Copay Changes $360,941	Primary Care: $35 to $45 Specialist: $45 to $55 Virtual: $0 to $10 ER: $150 + 20% to $250 + DED Urgent Care: 20% to $50 + 20%	ELIMINATE PLAN	Primary Care: $35 to $45 Specialist: $45 to $55 Virtual: $0 to $10 ER: $150 + 20% to $250 + DED Urgent Care: 20% to $50 + 20%
Rx Copay Changes $280,540	Tier 1: $10 to $20 Tier 2: $40 to $50 Tier 3: $60 to $70 Tier 4: $125 to $135	ELIMINATE PLAN	Tier 1: $10 to $20 Tier 2: $40 to $50 Tier 3: $60 to $70 Tier 4: $125 to $135
Premium Changes $395,400	Increase to Employees with Dependents Increase to City Subsidy	ELIMINATE PLAN	Increase to Retiree
Naviguard Implementation $300,000	Yes	ELIMINATE PLAN	Yes
Stop Loss Threshold Increase $225,687	Increase from $250K to $300K	ELIMINATE PLAN	Increase from $250K to $300K
Agency Contract Update $4,876	$75 PEPM to TPA Fixed Cost Plus 15%, Pass PCD Fee in Premium, EE's are RGV residents	ELIMINATE PLAN	$75 PEPM to TPA Fixed Cost Plus 15%, Pass PCD Fee in Premium, EE's are RGV residents
Direct Primary Care Approved $907,326	Yes - Employees & Dependents	ELIMINATE PLAN	No

Funding Outlook

The projections portray a need to act swiftly in order to properly fund expected claims for the next fiscal year. The funding deficit will require more than just a one time cost shift or benefit reduction as the revenue to claims ratio is not satisfied in short or long term.

The strategy drafted attempts to balance immediate cost shifting with incentivized engaged healthcare by plan members in an attempt to not only fill the hole presented, but also to work towards funding future fiscal years.

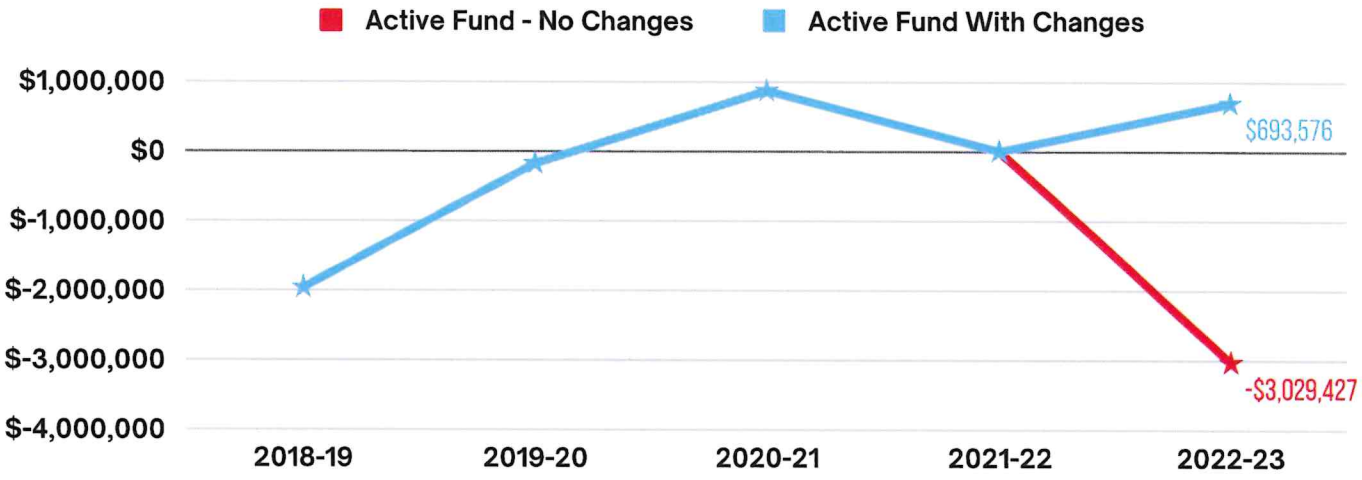
Should any of the recommendations not be considered, the funding hole equitable to that recommendation would need to be filled through continued benefits reductions, more dramatic premium increases or transfers from other funds.

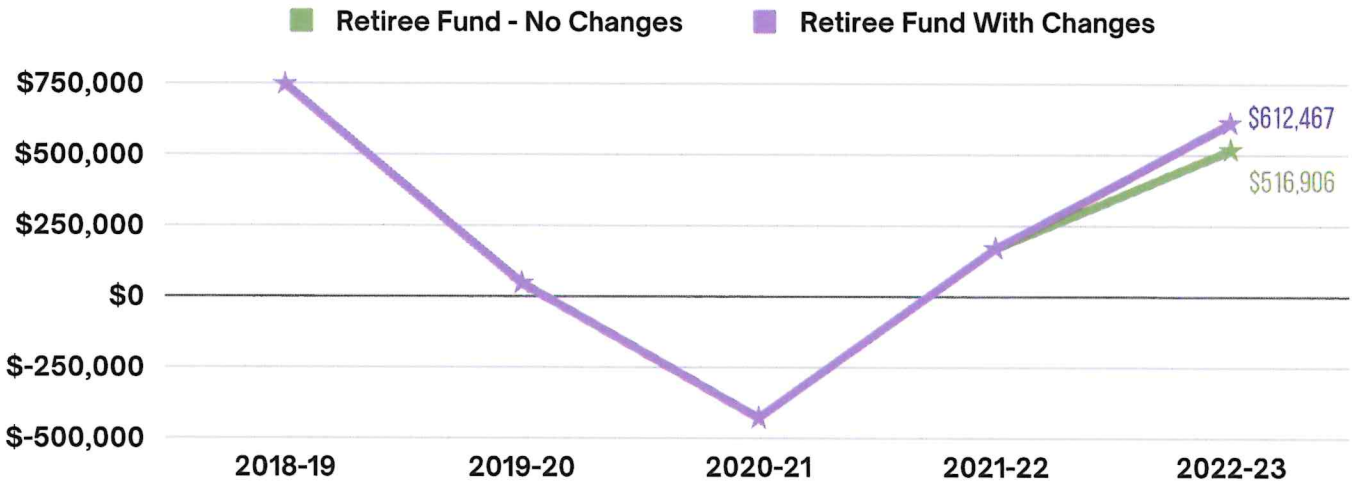
FY 2022-23 Projections	Active Fund No Changes	Active Fund With Changes	Retiree Fund No Changes	Retiree Fund With Changes
Beginning Fund Balance	$1,114	$1,114	$169,894	$169,894
Revenues	$13,213,985	$13,640,147	$1,655,507	$1,684,161
Health & Pharmacy Claims	$13,967,102	$9,027,059	$1,222,000	$961,998
TPA Fixed Costs	$1,699,944	$1,434,163	$86,494	$70,340
Administrative Expenses	$577,480	$2,486,463	N/A	$209,250
Ending Fund Balance	($3,029,427)	$693,576	$516,907	$612,467

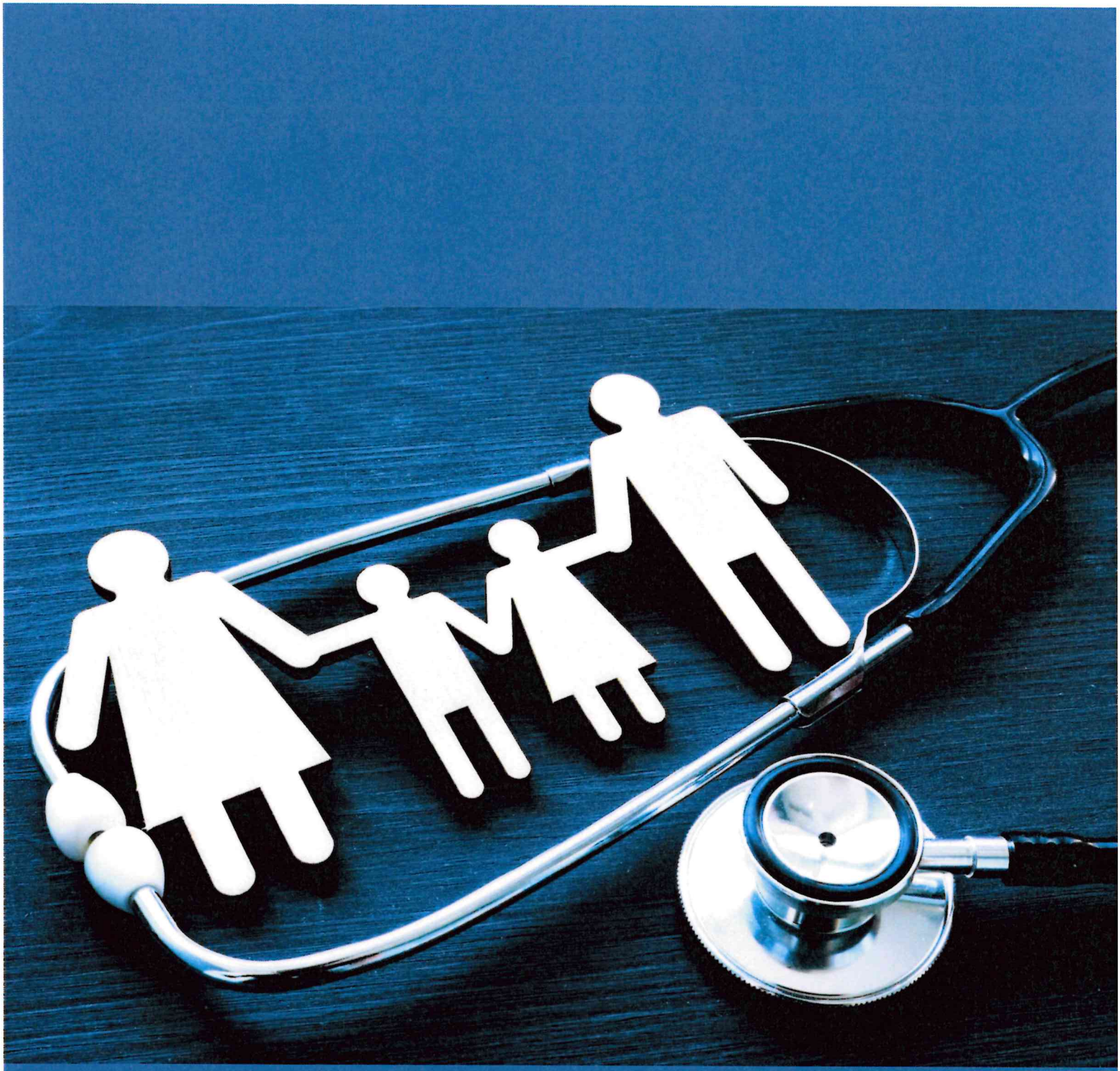
Fund Balance

EXPERIENCE & PROJECTIONS

Reflects the fund projection both without plan changes, as well as with all plan changes implemented.







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