



RFP # :2019-09-040YZV

Consultant Review

Gary R. Looney, REBC

3201 Cherry Ridge Drive

Suite D 405

San Antonio, Texas 78230

Phone: (210) 930-6665 Fax: (210) 930-1838

Memorandum

Date : September 24, 2019

TO : Hidalgo County Commissioner's Court

From : Gary Looney REBC

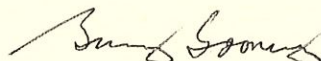
RE : "THIRD PARTY ADMINISTRATION, INDIVIDUAL STO LOSS FOR SELF-FUNDED MEDICAL PLAN, PAHARMACY BENEFIT MANAGEMENT SERVICES, GROUP TERM LIE AND ACCIDENTAL DEATH & DISMEMBERMENT, EMPLOYEE ASSISTANCE PROGRAM" RFP NO:2019-225-09-04-YZV

Recommendations:

- Renew medical administration services with Aetna
- Renew the Individual Stop Loss coverage with Aetna
 - The contract is a Paid/12 contract
 - The ISL limit is \$300,000
- Request workshop to discuss the Employee Assistance Programs and the proposals that have been submitted.
- Note, I will be requesting a Best and Final offer for the Group Term life and Accidental Death and Dismemberment proposals.
- Drop the medical Buy Up plan
- Increase benefits on the base plan as shown on spreadsheet Tab 3
- Include \$0 copay for diabetic maintenance medications

Thank you for your confidence in in my efforts to provide the best products and services at the least expense cost to the County.

Sincerely,



Gary R Looney REBC

Exhibit "B"

Evaluation Criteria Third Party Administration, Individual Stop Loss for Self-Funded Medical Plan

Final Scoring Grid

	Max Points	Aetna	United Healthcare	Blue Cross
Section 1 Administration (Includes cost of ISL)	3090	2569	2545	2364
Section 2 Network Providers	100	84	74	90
Section 3 Pharmacy	980	960	782	830
Section 4 Technology	95	95	95	95
Section 5 Wellness	300	280	300	300
Section 6 Additional Services	435	360	435	435
	5000	4348	4231	4114

Third Party Administration, Individual Stop Loss for Self-Funded Medical Plan, Pharmacy Benefit Services, Group Term Life & Accidental Death & Dismemberment & Employee Assistance Program

Hidalgo County

RFP: 2019-225-09-04

Third Party Administration

PROPOSER	AGENT 1	AGENT 2	AGENT 3	AGENT 4	AGENT 5	Addendum 1
AETNA	J. Salazar	Bob Treviño	Robert Garza			✓
BLUE CROSS BLUE SHIELDS	Bob Treviño	Jeff Everitt & Assocs				✓
* PROMINENCE HEALTH 1ST OF TX	NONE					X
UNITED HEALTHCARE	Bob Treviño	Jeff Everitt & Assocs	R.J. Garza	Puro Aseguro	Cuellar & Assocs.	✓

* Did not include Addendum #1

Individual Stop Loss For Self-Funded Medical Plan

PROPOSER	AGENT 1	AGENT 2	AGENT 3	AGENT 4	AGENT 5	Addendum 1
AETNA	J. Salazar	Bob Treviño	Robert Garza			✓
BLUE CROSS BLUE SHIELDS	Bob Treviño	Jeff Everitt & Assocs				✓
UNITED HEALTHCARE	Bob Treviño	Jeff Everitt & Assocs	R.J. Garza	Puro Aseguro	Cuellar & Assocs.	✓

Pharmacy Benefit Management

PROPOSER	AGENT 1	AGENT 2	AGENT 3	AGENT 4	AGENT 5	Addendum 1
AETNA	J. Salazar	Bob Treviño	Robert Garza			✓
BLUE CROSS BLUE SHIELD	Bob Treviño	Jeff Everitt & Assocs				✓
CERPASS RX	NONE					✓
* ENVISACARE RX	NONE					X
* PROMINENCE HEALTH 1ST OF TX	NONE					X
UNITED HEALTHCARE	Bob Treviño	Jeff Everitt & Assocs	R.J. Garza	Puro Aseguro	Cuellar & Assocs.	✓

* Did not include Addendum #1

Third Party Administration, Individual Stop Loss for Self-Funded Medical Plan, Pharmacy Benefit Services, Group Term Life & Accidental Death & Dismemberment & Employee Assistance Program

Hidalgo County

RFP: 2019-225-09-04

Group Term Life & Accidental Death & Dismemberment

PROPOSER	AGENT 1	AGENT 2	AGENT 3	AGENT 4	AGENT 5	Addendum 1
BLUE CROSS BLUE SHIELDS THRU DEARBORN METLIFE	Bob Treviño	Jeff Everitt & Assocs				✓
SECURIAN FINANCIAL	Robert J. Garza & Co					✓
UNITED HEALTHCARE	Bob Treviño	Jeff Everitt & Assocs	R.J. Garza	Puro Aseguro	Cuellar & Assocs.	✓

Employee Assistance Plan

PROPOSER	AGENT 1	AGENT 2	AGENT 3	AGENT 4	AGENT 5	Addendum 1
AETNA	J. Salazar	Bob Treviño	Robert Garza			✓
BLUE CROSS BLUE SHIELDS	Bob Treviño	Jeff Everitt & Assocs				✓
DEER OAKS	NONE					✓
UNITED HEALTHCARE	Bob Treviño	Jeff Everitt & Assocs	R. J. Garza	Puro Aseguro	Cuellar & Assocs.	✓

AGENT BINDERS

	Addendum 1
BOB TREVIÑO	N/A
JEFF EVERITT & ASSOCIATES	N/A
PURO ASEGURO	N/A
NEWKIRK & NEWKIRK	N/A

RFP # 2019-225-09-04-YZV

CONSULTANT ANALYSIS

TAB 1 RFP Analysis

TAB 2 Rate Guarantees

TAB 3 Policy Design Recommendation

TAB 4 Cost Analysis

TAB 5 Formulary Disruption

TAB 1

RFP Analysis

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RE : "THIRD PARTY ADMINISTRATION, INDIVIDUAL STO LOSS FOR SELF-FUNDED MEDICAL PLAN, PAHARMACY BENEFIT MANAGEMENT SERVICES, GROUP TERM LIE AND ACCIDENTAL DEATH & DISMEMBERMENT, EMPLOYEE ASSISTANCE PROGRAM" RFP NO:2019-225-09-04-YZV

Third Party Administrator Stop Loss Carrier Prescription Benefit Manager

A Request for Proposals was issued for THIRD PARTY ADMINISTRATION, INDIVIDUAL STOP LOSS FOR SELF-FUNDED MEDICAL PLAN, PAHARMACY BENEFIT MANAGEMENT SERVICES, GROUP TERM LIE AND ACCIDENTAL DEATH & DISMEMBERMENT, and EMPLOYEE ASSISTANCE PROGRAM due on September 4, 2019.

1. Third Party Claim Administrators (TPA) and Administrative Services Only (ASO)
 - a. Aetna (ASO)
 - b. United Healthcare (ASO)
 - c. Blue Cross and Blue Shield (ASO)
 - d. Prominence (TPA)
2. Individual Stop Loss (ISL)
 - a. Aetna (ASO)
 - b. United Healthcare (ASO)
 - c. Blue Cross and Blue Shield (ASO)
 - d. Prominence (TPA) did not provide insurance for ISL
3. Group Term Life and Accidental Death and Dismemberment
 - a. Dearborn National
 - b. MetLife
 - c. Minnesota Life
 - d. United Health Care
4. Pharmacy Benefit Management (PBM)
 - a. Aetna (ASO)
 - b. United Healthcare (ASO)
 - c. Blue Cross and Blue Shield (ASO)
 - d. Prominence (TPA)
 - e. CerrpassRx (PBM)
 - f. EnvisaCareRx (PBM)

5. Employee Assistance Programs

- a. Deer Oaks
- b. Magellen
- c. Optum
- d. Aetna
- e. ComPsych

A copy of the submissions is included in the cover jacket. There are submissions for Group Term Life and Accidental Death and Dismemberment and Employee Assistance plans. I will request a Best and Final quote for Group Life and EAP to present to the court. Neither plan is required to be enrolled through the County's enrollment portal. Introducing an EAP with managerial referral discretion requires discussion concerning County employment practices and County employee rights and privileges. I recommend the EAP selection to be carefully reviewed prior to selecting a carrier.

There were three (3) complete proposals received that included the medical plan Third Party Claims Administration (TPA) services integrated with Individual Stop Loss Insurance (ISL) and Prescription Benefit Management Services (PBM). There were no standalone ISL proposals.

The two independent PBM were interviewed. The fees, discounts, and the rebate process were examined. The independent PBMs are not integrated into the medical plan payment systems. Currently the rebate credits are applied directly to the administration fees. All carriers were requested to provide a portion of the annual estimated rebate as a current administration fee reduction. At the end of the plan year 100% of the actual annual rebate amount will be paid to the County. The independent PBM rebates were not paid until actually received which delays the rebate fee up to 180 days for the payment and quarterly after the initial period.

Scoring and Selection

The RFP uses a point system to score the RFPs submitted. There are six (6) elements scored:

1. Administration (Including cost of Individual Stop Loss Insurance))
2. Network Providers
3. Pharmacy
4. Technology
5. Wellness
6. Additional Services

The composite score of each element is compiled from the comparative analysis of each vendor's response to the RFP.

1. Administration

- a. Primary cost of Administration Fees for claim adjudication
- b. Plan of benefits for employees
- c. Fiduciary Liability
- d. Fees at risk for network discount performance guarantees
- e. Banking flexibility (Initial deposit?)
- f. Individual Stop Loss (ISL) annual cost
- g. Liability for high cost employee with increased individual deductible
- h. Expense or savings due to shared network utilization
- i. Accessibility for claim audits

Administration comprises 61.8% of the total points available. Administration includes the basic cost of claims adjudication. The initial fee is the gross fee charged per employee per month. However, because of the potential fee reduction available from the pharmacy credits generated by pharmacy rebates there must be a secondary evaluation based on the net cost of the administration fee and the efficacy of the proposed pharmacy benefit credit. The administration fees have to be considered both gross and net to achieve the best cost for the County. At present the County is utilizing the pharmacy rebate program to reduce the monthly administrative fees. The proposals received from Aetna, Blue Cross, and United Health Care have included an estimated rebate value used to offset basic administration fees with a contingent year end true up to 100% of the eligible rebates. The value that each carrier brings is accounted for in the scoring grid. The two standalone PBM offerings resulted in delayed communication between the medical plan and the pharmacy. The two standalone PBMs were too small and business experience too short to consider. It is not in the best interest of the County to choose either of the independent offers.

Each carrier has projected claims cost for the 2020 plan year. Each has predicated their estimate on changing the manner in which the healthcare of employees and covered dependents is managed. Insured members will receive specialized management for preventive care, wellness, diabetes management, and other manageable clinical issues.

Each proposal requires a change in the current prescription formulary to achieve medical plan cost reductions.

Aetna

Aetna has included in their proposal a new program Aetna InTouch Care (ATIC). The plan is designed to specifically identify an at risk member. The program includes three functions.

- Find- Identify potential health risks before they become high cost risks. The individuals identified through algorithms from claim history, biometric screenings, pharmacy utilization, preadmission authorization, post discharge, and hospice care as well as other flags.
- Engage-Once identified the ATIC nurses will reach out to member to encourage participation in managing their health.
- Help- AITC will provide access to on line programs for various health issues including but not limited to management of diabetes, high blood pressure, smoking, obesity, stress, and diet.

The Aetna proposal also includes MedQuery that tracks and identifies gaps in care and produces alerts to notify AITC nurses of non-compliant members. The notice to the ATIC nurses triggers a notification to the member and to the members treating physician for potentially high risk members.

The Aetna projects that the AITC program will reduce claims by 5%. Aetna has provided a claim guarantee for 2020. The claim guarantee is based on medical plan paid claims from January 1, 2019 through December 31, 2019. Aetna has provided an estimate for the 2020 plan year based on claims paid from September 1, 2018 to September 1, 2019. The illustration is shown in Tab 2. The illustration shows how a loss "pick" is calculated. The loss pick is an expected medical plan cost pepm. The sample shows that projected medical claims for 2020 would be:

$\$433 \text{ pepm} \times 3883 \text{ Employees} = \$1,681,339 \text{ Monthly } \$20,176,068 \text{ annually}$

This projection includes dropping the buy up plan and increasing benefits on the base plan. The guarantee puts at risk 50% of the gross administration cost. Approximately \$600,000.

UHC

In UHC's opinion, if the County were to select them as a provider, their approach to employees and their dependents, prior to a claim payment will generate significant claims cost savings for the County. Attached under Tab 2.

The UHC proposal has offered claim discount guarantee of 68.5% of eligible claims. They have also provided an expected medical and pharmacy loss "pick" of \$531.65 pepm. If the buy up plan is terminated the pick will be reduced to \$529.52. The "pick" guarantee period is for claims that are incurred in 2020 and paid by March 31, 2021. If you apply the formula to the current population the pick equates:

$\$531.65 \times 3883 \times 12 = \$24,772,763 \text{ paid claims incurred annually}$

This pick number is \$2.2 million less than the Lewis and Ellis projection of claims for 2019. UHC has offered an at risk penalty reimbursement if they do not meet their pick number. The scale starts at a penalty of \$191,200 if actual claims are \$567.31 pepm. Then, if off by \$20 increments at \$191,200 each incremental increase up to a maximum of \$651.90 or \$968,000 in penalties would apply. The example is under Tab 2.

The claim savings are generated by a change in the manner in which healthcare is accessed and the intensity of the employee to seek the proper care model and be compliant with the plan directions. Savings are also generated by discounting the eligible billed charges. They report that their current discounts are 70%.

The UHC proposal includes the payment of Out of Network (OON) claims at 110% of Medicare. This may generate a balance billing to your employee. Paying the out of network claims at a Medicare rate also impacts the percentage discount projections. Currently OON claims are paid on a customary and reasonable scale.

The County would be required to use the Flex Plan Formulary to guarantee the claim pick. There would be significant disruption with the change. Based on their report 484 drugs would have to be excluded. The disruption report does not identify the specific drugs exclude. UCH if provided a census with names and addresses would work with those employee impacted to move to a therapeutically equivalent medication that is on the formulary. The percentage discount guarantee and claim pick guarantee are under Tab 2. The formulary disruption report is under Tab 5.

Blue Cross

Blue Cross has offered a guarantee to pay claims at a minimum of 67.50% of savings off of eligible billed charges. They also guarantee that 98.1% of all claims will be in network. Blue cross has not offered a guarantee of fees on a medical plan "pick". They have estimated the annual expected medical only claim limit to be \$24,529,223. The guarantee to meet their discount factor of 67.5% is 20% of fees (Maximum \$300,000) if the percentage of savings is not met and 10% (Maximum \$150,000) if the in network percentage is not met. This is a total of \$450,000. The example is under Tab 2

Blue Cross has offered to use their broadest prescription formulary for the first year but must move to the performance formulary in years 2 and 3.

Claim Fiduciary

It is important to identify the claim fiduciary. The claim administrator should be the claim fiduciary to protect the County against claim denial review. If a claim is denied there is an appeal process required to be provided. The fiduciary will handle the claim denial and appeal process for the County. The initial claim review will be handled internally by the carrier. An External Review Organization (ERO) may be used if issue is not resolved internally. The fiduciary responsibility insulates the Court from making claim payment decisions.

Individual Stop Loss

The Individual Stop Loss insurance (ISL) is an important coverage for the County. There were no standalone ISL offers proposed. Aetna is the current claim administrator as well as ISL carrier. The carrier ISL combination is the most efficient method of providing stop loss coverage reimbursements. Currently any claim in excess of \$300,000 is immediately paid by the Aetna. Premium comparison is under Tab 4.

Plan Design Changes

Attached is a recommendation for plan benefit changes for the County plan. Each company can support the plan of benefit changes. The changes are able to be made due to the savings from the removal of the Buy-Up plan and reduction in fixed costs. The projected 2020 budget is sufficient to provide the changes. See Tab 3.

2. Network Providers

- a. Hospital access local, regional, national, international
- b. Primary Care physician access
- c. Specialty Care physician access
- d. Urgent care center, walk-in clinics, telephonic access, virtual appointments
- e. Centers of excellence access
- f. Transplant centers of excellence
- g. Patient advocacy programs

Aetna UHC Blue Cross

The network of providers is important to assure that employees have access to as many physician, hospital, and tertiary providers as possible

All bid responses provide access to an adequate number of Primary Care and Specialty Physicians to serve the County. Additional information about the available measurement tools to help an employee select a provider from the network were presented. Carriers are now providing information about the Quality of the Services being provided by a physician and making recommendations to members. How that information is made available to an employee is a factor in the scoring process and under the technology scoring grid.

Access to urgent care facilities and walk-in clinics, telephonic, and virtual appointments are included in the assessment of the vendor. The proposers have each identified Centers of Excellence. These medical facilities specialize in the treatment of specific medical conditions, i.e., M D Anderson Cancer Center in Houston. There are other facilities that specialize in specific surgical procedures, rehabilitation centers, and other facilities identified as the best facilities for positive outcomes.

The proposers have identified Transplant Centers of Excellence include specialty hospitals the deal with liver, lung, kidney, heart, pediatric, and other transplant issues.

UHC has physician match of 97% in network or 3% disruption with Aetna
Blue Cross has physician match of 98% in network or 2% disruption with Aetna

3. Pharmacy

- a. Pharmacy network
- b. Cost of administration
- c. Formulary comparison
- d. Discounts through retail purchase, mail order, specialty meds.
- e. Rebate contract
- f. Transparent and Traditional offers
- g. Local non chain participation with 90 day supply
- h. Integrated with claim system
- i. Reporting capability

The Prescription Benefit Management (PBM) section of the bid responses is very extensive. The PBM's contract for services is very complicated and based on the evaluation of formulary and cost, the end result will affect virtually every employee of the County.

A formulary is the placement of a specific medication into an accessibility category, copay tier, and therapeutic category. A formulary may exclude certain medications. The exclusions are often based on cost of medication and the rebate contract the carrier has with the manufacturer. Many medications have generic equivalents, especially disease management medications. The current formulary requires the use of an available generic or require that the difference between the cost of the generic and the brand to be paid by patient. The formulary may also require that a lower cost generic be used first as opposed a brand medication. Other medications my require pre authorization.

Aetna Formulary

In order to receive the full value of the rebate credits that are being offered to the County it is necessary to use a different formulary than is in place today. The new formulary will exclude several drugs. The disruption report under Tab 5 from Aetna indicates that 285 individuals would be impacted by the formulary change. The Aetna has agreed to grandfather the impacted employee for one year. Each will be contacted to be told of the future change in the formulary. Aetna will reach out to each to help move to another therapeutically equivalent medication.

Other employees will be impacted by an increase in the co-pay amount based on a change in the co-pay tier. The movement from Tier 2 to Tier 3 impacts 21 employees. The change in co-pay is an increase of \$15 per script. All of the medications have therapeutic equivalents. There is also a positive shift in the medications covered from Tier 3 to Tier 2. There are 114 employees who will pay \$15 less for their prescriptions.

The grandfather status will last for one full year starting in January. An effort will be made by Aetna to help employees change to a covered medication that is a therapeutic equivalent. If the change is not possible due to medical necessity then the treating physician may request an exception.

UHC Formulary

The UHC formulary proposed is their Flex Plan. The Flex plan disruption indicates a 4.1% negative change. The number of prescriptions negatively impacted for the year 2018 was 2,066. Positive impact was 1,333. These were individual scripts written for a full year. The negative impact by script counts each time the script was filled. The actual number of employees negatively impacted was not included in their report. The names of employees were not in the census provided due to HIPAA concerns. However, of major impact, is the 484 drugs that will be removed completely from the formulary. There are 484 drugs that would have not been covered by the Flex plan for 2020.

In order to control the cost of the medical plan the Flex Plan formulary is necessary component of the cost savings. While many drugs are excluded there are many therapeutic equivalents that could be substituted. If UHC is provided a report that includes the name and address of the impacted employee they will reach out to that employee and their physician to select a script that is on the formulary.

Blue Cross Formulary

Blue Cross has proposed that the formulary provided to the County would be their broadest based formulary which would have the least impact on the County's employees. In order to offer this broad network it is necessary for the County to move to the Blue Cross Performance formulary in 2021. As with UHC if provided a report indicating the employee's name and address they would reach out to them in order to keep them within the Performance network. The rebate structure will remain in place as proposed for 2020. The shift from Broad to Performance is a significant disruption.

The request made of all primary responders was to provide a monthly estimated credit PEPM to be used to offset the medical plan administration fees and the Individual stop loss premium. At the end of the policy year 100% of the rebate reimbursement will be calculated and if the total is greater than the estimate the excess is paid to County. If less than the estimate the cost is absorbed by the carrier.

Each carrier has agreed to provide the diabetes management medications at \$0 copay.

4. Technology

- a. Website access, comprehensive and user friendly
- b. Telephone access APPS for iPhone and Android
- c. Employee portal for service questions and provider selections
- d. Employer portal
- e. Access to reports
- f. Access to claim history
- g. Access to eligibility
- h. Monthly and Annual reports required by County

AETNA UHC Blue Cross

All of the carriers have significant internet access, specific web based applications, and the technology to provide communication sites for multipurpose use. Virtual visits and telephonic assistance is offered by each carrier. The evaluation considers the ease of access and the results generated by the contacts that are made. Access must be readily available with successful resolution to the questions asked by employees. Carriers have presented a synopsis of their web based tools. It is important for County employees to be educated on the use of the tools that are available to them. Only experience will show if employees will take advantage of the tools offered.

5. Wellness

- a. Active or Passive wellness tools
- b. Cost of programs available funding
- c. Biometric Screenings integrated/nonintegrated
- d. Disease management (Cardiac, Pregnancy, Diabetic)
- e. Pro Active Preventive Care

Wellness plans have the capacity to identify medical risks and help reduce plan cost by early intervention and prevention of health claims.

Aetna

AETNA is working with Diana Huallpa – the County’s wellness program coordinator works using resources from Aetna for Healthier Challenges and promotional items for wellness.

Aetna In Touch CareSM (AITC) Solutions program, which redefines care management. Addresses chronic and acute conditions holistically, instead of through separate case management and disease management programs, with the help of cutting edge technology. Caring for members through a single nurse model that even assigns the same nurse to family members. Identifying the members who need help the most through a series of intelligent algorithms

Diabetes Management Plus is our coordinated approach to diabetes management. Focused on comprehensive condition management, the program combines one-on-one nurse/coach care from Aetna, remote glucose monitoring in collaboration with Livongo. Its clinical workflows are integrated into care management programs providing a seamless consumer-centric experience with focus on self-management, including an app that tracks activity and sends reminders, and customized options for engagement (via text, call, email, etc.). All the support provided is based on where the employee is in their health journey.

Educate employees on Aetna Online Health Assessments through “Simple Steps to A Healthier Life” in Aetna’s Navigator System.

UHC

PERSONALIZED ONLINE WELLNESS ENGAGEMENT WITH RALLY

Rally provides a digital avenue for The Hidalgo County members to engage with well-being programs and earn incentives, integrated with all clinical and coaching programs and support.

UHC digital hub, cobranded for the County, incorporates data from each member’s profile (including biometric screening data from Onsite Health Diagnostics), their health care experience and preferences “up to now”. Through proprietary data analysis, it delivers personalized recommendations and healthy actions to members (which match those from our coaches and clinical team) that we know they are most likely to take part in, based on what we know about them.

Recommendations are dynamic, and change according to a member’s progress, health and lifestyle needs. You can also select digital campaigns to promote specific programs. From a health survey, provider search, and Missions, Challenges and Communities, to education and connectivity to The Hidalgo County benefits, resources and third-party programs, every member has an opportunity to improve their health and lifestyle.

REAL APPEAL: WEIGHT MANAGEMENT PROGRAM

The County’s top two costly conditions are diabetes and weight complications. UHC helps address these cost drivers with Real Appeal, a proprietary 52-week intensive weight management and intervention program.

Real Appeal’s ultimate goal is preventing or mitigating obesity related issues such as prediabetes, diabetes and cardiovascular disease. The curriculum is based on more than 20 years’ worth of clinical research regarding obesity, weight loss and disease management.

Blue Cross

Well onTarget® Member Wellness Portal - Personalized action plans, along with fitness and nutrition device integration, jump start each employee's journey toward overall wellbeing. Topics include: Stress, weight loss, tobacco cessation, asthma, diabetes and other chronic conditions, Sleep and health

Fitness Program - Eligible employees and their dependents have access to a range of nationwide fitness centers for \$25 a month. Not stuck with one location and brand.

Blue PointsSM - Redeem points for doing healthy activities like taking a Health Assessment, enrolling in a self-management program, joining the Fitness Program or using a fitness tracker.

Digital Health Partners - Complementary digital coaching delivered by premier, preferred vendors helps reduce risks involved with costly chronic disease categories, including: **Naturally Slim** - Weight Management, **Omada Hypertension Program** targets the population at risk for obesity-related chronic disease. **Livongo** - delivers programs for type 1 and type 2 diabetes management.

6. Additional Services

- a. Enrollment services
- b. Policy Booklets, SBCs, SPD.s
- c. Local office, designated service representative, on site
- d. Dedicated billing administration service representative
- e. Ability to service account
- f. Financial strength
- g. Reference check
- h. AM Best ranking
- i. Industry Experience with Public Entities
- j. Annual reporting required by Affordable Care Act
- k. Bilingual capacity

Aetna

Each one of the services is provided by Aetna with the exception of the local service office. Aetna is in the process of hiring or moving a service representative to Hidalgo County as soon as possible. Aetna has provided quality customer service from Kip Hill for claim questions, and Wayne Parker for policy issues, and Louwana Pope for daily inquiries and reporting.

UHC

UHC provides each of the service line issues. Their local service office is in Harlingen with additional back up in their Houston office. UHC is one of the largest carriers in Hidalgo County with members from major corporations throughout the County. UHC has made a commitment to provide quality service to the County.

Blue Cross

Blue Cross is recognized name and entity in Hidalgo County. The County was with Blue Cross as a carrier and has experience from the local customer service representative. Blue Cross would be a quality service provider.

Budget Office Concern

There is concern by the Budget office about the method of claim billing payments and the financial obligations of the County to fund the payment of the claims cost as the expenses are incurred. Blue Cross and Aetna have both approved the current funding method. United Health Care has not yet approved a funding method.

United Health Care prefers to have an account that is funded in advance by the County. The County would be required to maintain a balance in the account. Initial deposit is \$590,000. As checks are cashed the account is reduced and expected to be replenished to a standard operating level for reimbursement. Checks that are cashed are paid by the account with the ISL reimbursement only charged up to the ISL limit. UHC will charge a late fee if funding is not made on a timely basis. They expect funding to be every two weeks.

Medical Plan Employee Premium Rates

The County will continue to provide the basic medical plan to all full time active employees at no cost to the employee.

The Lewis and Ellis actuarial evaluation recommends an increase in the funding for the 2020 plan year, assuming no plan changes, at a 6% increase.

The actuarial evaluation also revealed that the premium differential between the Basic Plan and the Buy Up Option was not sufficient to support the plan benefit options. The Buy Up option was essentially priced too low in relationship to the benefits offered. As a result, I recommend dropping the Buy Up Option. An alternative would be to charge the appropriate premium which would cause employees to shift to base plan. The savings achieved by eliminating the option may be used to enhance the base plan benefits. Options are included are included under Tab 3.

The spreadsheet showing administrative cost comparison for the first year is under Tab 4. The second year estimate is under Tab 4.

Pros and Cons

Administration (Including cost of Individual Stop Loss Insurance)

Aetna

PRO

- No rate increase for stop loss premium
- Removed any lasers (lasers are higher deductibles for an individual)
- Current reimbursement direct when ISL threshold is reached
- Incumbent administrator
- Lowest net cost using PBM discounts and premium waiver credits
- Contracted with new Tenet facility in Weslaco for discounted co-pays
- Comprehensive Quality assurance guarantees
- Currently searching for customer service personnel for valley
- Banking and payment system coordinated
- Direct access to Aetna claim director
- Expense Credits
 - Wellness benefit credit \$25,000 first year
 - \$50,000 second year
 - \$75,000 third year
- \$440,000 premium waiver for 2019
- Addition of Aetna in Touch Care (AITC)
- Special contracts with South Texas
- Special contracts with urgent care centers being opened by DHR
- Valley Baptist special low co-pay for doctor visits
- Minimal Formulary disruption
- Lowest 2nd and 3rd year admin fees
- Adding mini-clinic in Weslaco with 8 doctors and reduced copay

CON

- Reporting module is complicated
- Currently no local support to provide ongoing service and education
- Employee perception

UHC

PRO

- Equivalent ISL rate to renewal
- Reimbursement direct when ISL threshold is reached
- Expected claim pick at \$24.7 million with fees at risk
- Reporting package is complete
- Initial wellness credit \$50,000
- Transition allowance \$500,000
- Local experienced service representative

CON

- Awaiting review of disclosure statement to firm up quotes
- Funding requirements are not compliant
- Not responsible for agreement between Summary Plan Description and ISL contract
- Knapp hospital not in network
- Overall cost control requires use of recommended Flex Formulary
- Formulary disruption is most common concern

BC/BS

PRO

- Local known account manager known from previous BC period
- Positive Employee Name recognition
- Cost reduction over current plan expenses
- \$750,000 transition credit
- \$250,000 PBM credit
- \$250,000 additional transition credit
- Well Being Management Included Holistic Health Management
- Blues subcontract with multiple providers for Well Being Management
- Benefit Value Advisor access for employees
- Member Rewards program to incent employees to use lowest cost provider

CON

- admin fee before and after Rebates
- Work around for pharmacy
- Highest stop loss premium
- High 2nd and 3rd year cost increase without transitional relief
- Movement to Performance formulary

Network Providers

Aetna

Pro

- Incumbent provider; employees have established providers
- Addition of Tenet facility in Weslaco with lower copay
- Addition of Diabetes Management program Livongo Program
- Fee negotiation with DHR Urgent Care facilities
- Transplant centers of excellence are in network
- Currently 97.1% of office visits are in network
- Currently 99% of hospital admissions are in network
- 71.3% Ambulatory Hospital discounts
- Current 67.9% discount (Skewed by U&C out of network payments)

CON

- Employee perception

UHC
PRO

- One universal network
- Tiered providers based on quality assurance measures
- Easy to maneuver through portal
- Centers of excellence, access through Advocate4me service model
- Currently claiming 71.5% network discounts
- Sufficient number of providers

CON

- Knapp Hospital is not in network
- Required Medicare reimbursement at 110% for OON

BC/BS

PRO

- Discount target is 67.5%
- Largest Network, 98.1% of all claims in network
- Navigation tool through entire network through Benefit Value Advisor
- Member Rewards program for employees who use lowest cost providers
- MDLive virtual visits (Phone, online video, Mobile App)
- Clinical Claims validation unit
- Well onTarget portal for wellness
- Blue Points rewards to encourage healthy behavior
- Added Livongo Diabetes Management

CON

- Cost for Member Rewards born by County
- High Second and Third year costs
- Formulary disruption work around for first year
- Required movement to Performance Formulary

Pharmacy

Aetna

Pro

- Minimal formulary disruption
- Upfront payment estimate of rebates approved
- Rebate guarantee at 100%
- Totally integrated
- No downside at this time

CON

-

UHC

PRO

- Upfront payment estimate of rebates approved
- Requested plan design approved
- Rebate guarantee at 100%
- Totally integrated
- With employee census on prescription report UHC will help in Rx movement

CON

- Formulary required for claims pick
- Disruption of 4% - 5.9% of negative movement depending on which formulary is selected
- Potential EE dissatisfaction

BC/BS

PRO

- Upfront payment estimate of rebates approved
- Rebate guarantee 100%
- Traditional broad formulary included in work around
- Totally integrated

CON

- Work around to use least disruptive formulary requires movement to strictly managed performance network to achieve rebates

Technology

Aetna

Pro

- Easy access to personal information on line through web portal
- Teladoc
- Aetna portal for employee use through Doc Find
- Provider finder through employee portal
- Health Risk Assessments on line

CON

- Teladoc not being used

UHC
PRO

- Personal Health Support team helps to make smart choices for health care
- Virtual office visits by phone, through App, or online.
- Telemedicine
- Advocate4me provides guidance for employee to select physician
- Advocate4me has a special needs advocacy program

CON

-

BC/BS
PRO

- MDlive for virtual visits
- Multiple web based tools
- Benefit Value Advisor is a critical tool

CON

-

Wellness

Aetna
Pro

- Wellness incentive \$25,000 1st year, then \$50k and \$75 K
- Diabetes management Livongo Glucometer
- Aetna has confirmed ability to have \$0 copay for all diabetic medications
- Annual additional claim cost estimated to be \$111,000
- Training provided for County's wellness coordinator
- Health Risk Assessments online
- Many tools available to wellness coordinator

CON

-

UHC
PRO

- Wellness incentive \$50,000 each year
- Rally wellness incentives challenges and rewards
- Real Appeal weight loss program
- Wellness coach by group or individual
- 50 missions to accomplish to earn credits

CON

- Real Appeal cost up to maximum of \$800
- Claim cost indeterminate

BC/BS

PRO

- Benefit Value Advisor for wellness
- "AlwaysOn" mobile app
- Blue Access for members
- Diabetes management Livongo Glucometer
- MDlive for wellness plans

CON

-

Additional Services

Aetna

Pro

- Enrollment support
- Account manager position approved for Valley
- Reporting structure conforming to County's request
- Available for health fairs
- Work with County's wellness coordinator
- Access to Plan Sponsor Liaison for claim help

CON

- No local account manager as yet

UHC

PRO

- Local account manager
- Assigned regional manager
- Available to train the trainer for employee orientations
- Available for Health fairs
- Enrollment support

-

CON

-

BC/BS

PRO

- Local account manager
- Available for health fairs
- Enrollment support

CON

-

-

TAB 2

Rate Guarantees

Claim Target Guarantee

County of Hidalgo



What we guarantee

We guarantee that your paid guarantee period claims will not exceed your prior (base) year claims by the trend percentages shown below.

Current Products: Aetna Choice[®] Point of Service II (CPII)

1/1/2020	
Guarantee period	January 1, 2020 through December 31, 2020
Base period	January 1, 2019 through December 31, 2019

Savings factors will be determined based on the plan that is implemented. For the purpose of this illustration we used paid claims from September 1, 2018 to September 1, 2019. Numbers shown are illustrative. Factors for each plan option are as follows:

Option 1 - Current Plans Aetna Choice POSII

Proposed Aetna Enrollment of 3,868 active employees /6,668 members in CPII		Factor
Base Year Medical Paid Claims (per employee per month) based on current CPII experience on PEPM basis		\$411
Network Discount Improvement	X	.98
Aetna In Touch Care Solutions Improvement Factor	X	0.935
Trend Factor	X	1.093
Net Effective Trend Estimate	=	1.00
Projected Claim (per employee per month)	=	\$411

Option 2 Alternate– Open Access Aetna Select

Proposed Aetna Enrollment of 3,868 active employees /6,668 members in OA AS		Factor
Base Year Medical Paid Claims (per employee per month) based on current CPII experience on PEPM basis		\$411
The Differential between the Proposed Product & existing Choice POSII plan Design	X	.914
Network Discount Improvement		.98
Aetna In Touch Care Solutions Improvement Factor	X	0.935
Trend Factor	X	1.093
Net Effective Trend Estimate	=	0.915
Projected Claim (per employee per month)	=	\$376

Claim Target Guarantee

Option 3 Alternate–Choice POSII

Proposed Aetna Enrollment of 3,868 active employees /6,668 members in CPOSII		Factor
Base Year Medical Paid Claims (per employee per month) based on current CPII experience on a PEPM basis		\$411
Network Discount Improvement	X	0.98
Aetna In Touch Care Solutions Improvement Factor	X	0.935
Proposed Plan Changes to Buy Up and Basic Plans	X	1.052
Trend Factor	X	1.093
Net Effective Trend Estimate	=	1.054
Projected Claim (per employee per month)	=	\$433

Plan changes would include dropping the Buy Up plan, and change deductible, copays and coinsurance on Base plan.

How the guarantee is calculated

We calculate target paid claims per-employee, per-month (PEPM) by multiplying base year claims times the net paid effective trend adjustment. Claims processed in excess of \$300,000 are excluded from the total paid claims of both the base year and the guarantee period. Six months of runout data will be included in the calculation for the base and guarantee periods.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for:

- Changes in plan design from baseline period to projection period
- Changes in demographics, geography
- Plan changes or product changes

Claim Target Guarantee

Guarantee reconciliation

We compare the target paid claims PEPM to the actual paid claims PEPM to determine whether or not we meet the performance guarantee. Based on the outcome of the comparison, we will make any applicable fee adjustment as shown in the table below.

Fee adjustment	Maximum guarantee period adjustment
<p>1.0% fee reduction to the per-employee, per-month fee for each full 1.0% of the difference of actual claims above 102% times the target paid claims</p>	<p>40% of actual collected administrative service fees *</p>
<p>Aggregate maximum</p>	<p>50% of actual collected administrative service fees for all guarantees combined^s</p>

* "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee. Administrative service fees exclude:

- Program fees at risk in the Aetna Demonstrating Value Scorecard
- Wellness allowances
- Any charges for services performed which are not included on the monthly administrative service fee bill

Claim Target Guarantee

Conditions for the guarantee	
<p><i>We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the net allowed trend. We reserve the right to revise or remove the guarantee if any of the following conditions are not met.</i></p>	
Category	Condition
Group size variation	The enrolled group does not vary in size by more than 10 percent from the average enrollment in the base year. Our assumption is that 3,868 active employees/6,668 members will enroll in our medical plans. COBRA, pre-65 retirees, post-65 retirees and disabled employees are not included in this guarantee.
In-network utilization percent	Your Aetna medical plan's in-network claim dollar utilization percent varies by less than 0.5 percent from the base year to the guarantee year.
Benefits plan conditions	<p>Your plan design includes:</p> <ul style="list-style-type: none"> • Steerage from emergency room to urgent care facilities and/or walk-in clinics • Steerage from hospital-based services to free-standing facilities • A minimum \$20 primary care physician/specialist copay and/or \$500 deductible
Medical management program requirements	<p>You include the following medical management programs:</p> <ul style="list-style-type: none"> • Aetna In Touch CareSM Solutions • MedQuery • PHR

Claim Target Guarantee

Financial incentives

You provide financial incentives to encourage employees and eligible family members to take part in yearly health risk assessments and have biometric screenings that are right for them. We recommend a financial incentive of \$75 or more per employee. We'll provide you with the tools and our online health assessment model as part of your offering. We'll even help you organize onsite biometric screenings and manage the incentives that you prefer to offer your employees

You deliver quarterly communications to your employees and retirees that stress the importance of health promotion, wellness and prevention. Quarterly communications are delivered during and outside of Open Enrollment. If interested, our Customized Communications Group (CCG) can help you with your communications strategy and efforts.

Subrogation

Subrogation services through our third-party vendor are included.

Pharmacy claims

Pharmacy and specialty pharmacy claims are excluded.

Coverage termination during guarantee period

The Medical Claim Target Guarantee is considered met if you terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal prior to the end of December 31, 2020.

The table below provides the in-network savings for those markets with the largest number of employees based on the Hidalgo County network match. These savings will be utilized to determine Hidalgo County's final Target In-Network Savings Percentage based on actual enrollments by market.

Market Name	Employees	Employee %	In-network Savings
RIO GRANDE VALLEY	3,831	100.0%	68.5%
Total/Average*	3,831	100.0%	68.5%

Groups added by after the plan's effective date will be factored into this guarantee according to their date, size and enrollment by network.

A minimum of 3,445 total employees enrolled in the UnitedHealthcare plan is required for the Network Savings Guarantee to remain in effect.

UnitedHealthcare reserves the right to revise this quotation under the following circumstances:

- The benefits requested and/or quoted change prior to or after the effective date of this quotation.
- An award is not made within 90 days of the issuance of this quotation.
- Changes in federal, state or other applicable legislation or regulation require changes to this quotation.

UHC reserves the right to adjust the discount guarantee should provider chargemaster increases (the rate by which provider charges increase) vary from assumed levels.

* These numbers are estimated only. Final numbers will depend on actual enrollment by network.

At the time of reconciliation, discounts will be calculated per the language set forth in this guarantee and may not match figures shown in other client reports produced throughout the year.

UnitedHealthcare
Net Cost Guarantee

Effective for Policy Year Beginning: January 1, 2020

UHC ASO Billable Admin Fee	\$41.33	\$1,913,000	Annual ASO Base Fees
Percent of Fees @ Risk	50%	\$956,000	Annual Fees @ Risk
Fees @ Risk	\$20.67	3,857	Number of Employees
Target Claim Factor	\$531.65		

Risk Free Corridor>>	Claim PEPM		Amount at Risk
	\$515.70	up to	\$547.60
	\$547.61	up to	\$567.31
	\$567.32	up to	\$587.73
	\$587.74	up to	\$608.89
	\$608.90	up to	\$630.81
	\$630.82	up to	\$651.90
			\$0
			\$191,200
			\$382,400
			\$573,600
			\$764,800
			\$956,000

} UHC pays the customer

Assumptions and Caveats:

- Guarantee is effective for the quoted plan year only.
- Illustration assumes the following services/programs will be included in the employee benefit plan:
 Experience: Billed to Eligible, Real Appeal,
 Clinical/RX Integration: Importation of 3rd party RX Data, Pharmacy Integration overall Medical and RX if Advantage PDL, CPHS (TX),
 Plan Design: Medical Neccessity & Prior Authorization, Virtual Visits (TeleHealth), OON Reimbursement,
 Network Design: OON Reimbursement, NEF,
- The number of covered employees assumed in this proposal is listed below by plan offering:

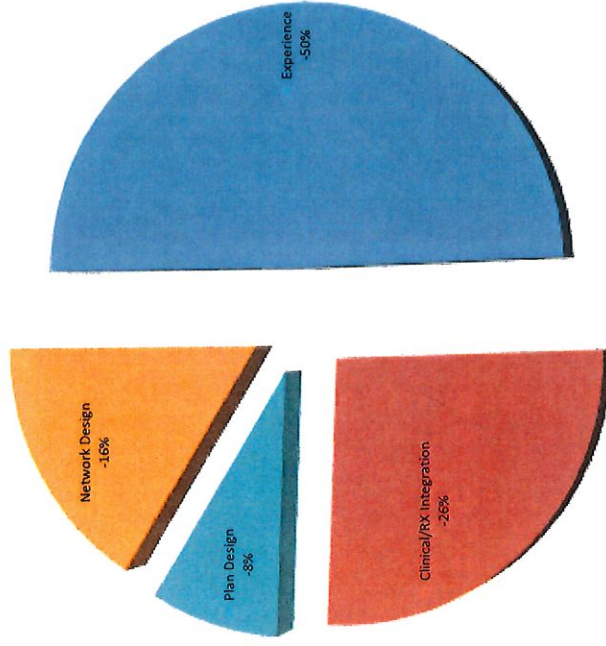
<u>Quoted Choice</u> <u>and Choice Plus Plans</u>	<u>Assumed Monthly</u> <u>Covered Enrollees</u>	<u>Claim Target</u> <u>Factors PSPM</u>
Choice +	3857	\$531.65
COMPOSITE	3857	\$531.65

This guarantee only applies to employees enrolled in Choice and Choice + products.
- Reconciliation will be based actual covered lives by plan during the plan year and the claim target factors by plan listed above.
- Reconciliation will be based actual claims INCURRED from January 1, 2020 to December 31, 2020 and PAID from January 1, 2020 to March 31, 2021
- Reconciliation will be performed within 180 days but no earlier than 120 days after the close of the plan year.
- Actual claims include all Medical claims and Pharmacy claims if applicable, except for the following:
 - Benefits for services incurred prior to the effective date of the policy.
 - Losses in excess of \$300,000 per covered individual.
 - Losses in excess of usual and customary for out of network claims.
 - Losses associated with benefits not covered by the underlying employee benefit plan, but paid by the employee benefit plan.
- Maximum guarantee payout is \$956,000.
- Assumes UnitedHealthcare is the only carrier offered.
- United Healthcare reserves the right to adjust the projected target claim factor or rescind this guarantee under any of the following circumstances:
 - Enrollment in total or by plan varies +/- 10% or more from the assumptions listed in this proposal.
 - An award is not made within 90 days of the issuance of this proposal.
 - Changes in federal, state or other applicable legislation or regulation require changes to this proposal
 - Changes to any of the included services/programs listed in item 2 above.
 - Any changes made to the plan of benefits offered covered by this guarantee.
- Guarantee is provided in lieu of any Network Discount Guarantees previously quoted.

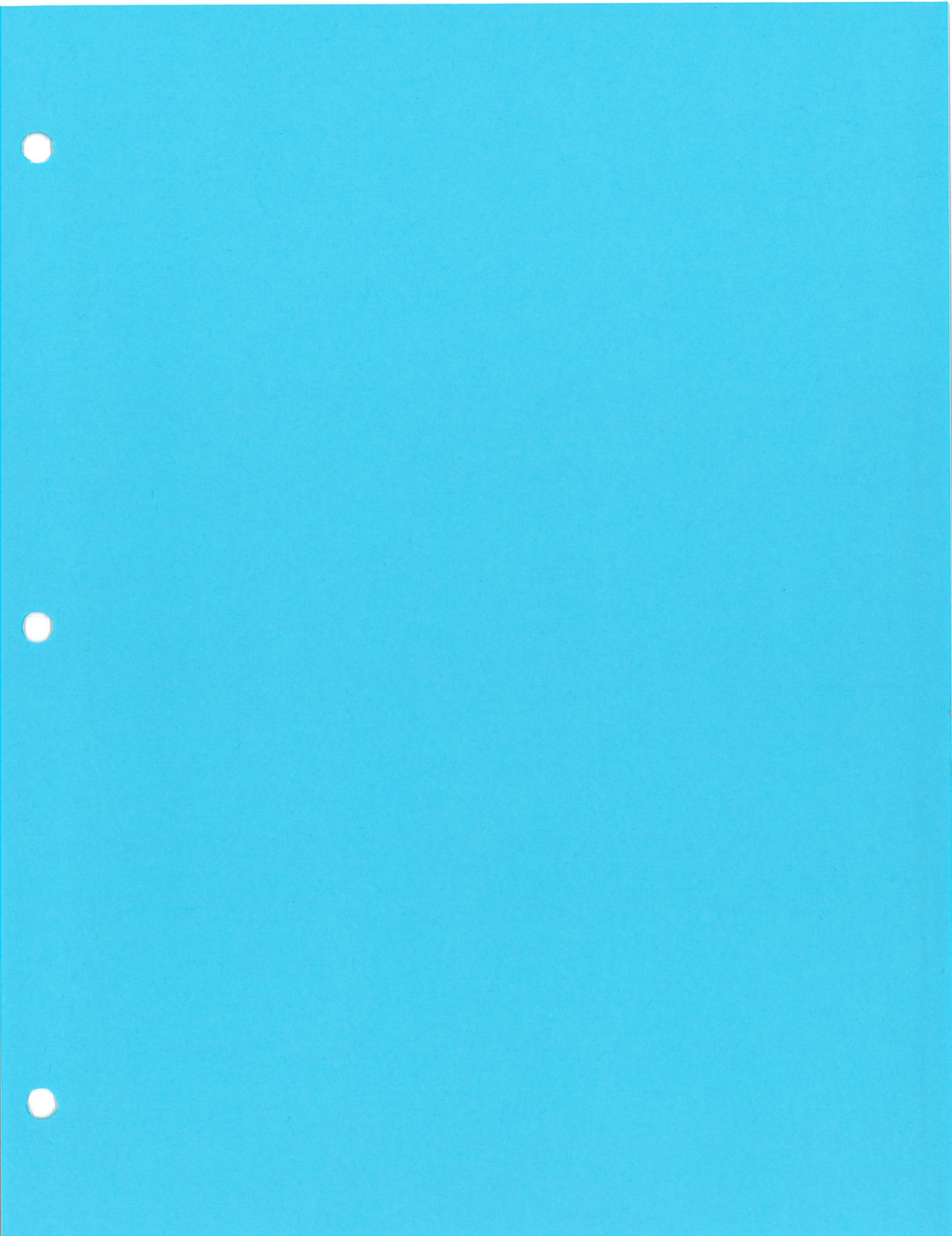
UnitedHealthcare
Net Cost Guarantee

Customer Name: Hidalgo County (TX)
Effective Date: 1/1/2020
Subscribers: 3,857

Overall Savings by Category



	Per Employee Per Month (PEPM)	Current Plan	Annual Dollars
Expected Claims Projection	\$602.87		\$27,903,090
Experience	Savings PEPM (\$35.32) Billed to Eligible, Real Appeal,		Savings Annual Dollars (\$1,634,763)
Clinical/RX Integration Importation of 3rd party RX Data, Pharmacy Integration overall Medical and RX if Advantage PDL, CPHS (TX),	(\$18.53)		(\$657,581)
Plan Design Medical Necessity & Prior Authorization, Virtual Visits (Tele-Health), OON Reimbursement,	(\$5.79)		(\$267,994)
Network Design	(\$11.58) OON Reimbursement, NEF,		(\$535,988)
Total Claim Savings	(\$71.22)		(\$3,296,325)
Net Cost Guarantee	\$531.65		\$24,606,765





Hidalgo County

January 1, 2020 - December 31, 2020
In Network Utilization Guarantee

Medical Claims Only
Claims Paid 01/01/20 Through 12/31/20

Guaranteed In Network Utilization 98.1%

Actual In Network Utilization		Admin Fee Penalty
97.10%	or Higher	0.0%
96.60%	to 97.09%	2.0%
96.10%	to 96.59%	4.0%
95.60%	to 96.09%	6.0%
95.10%	to 95.59%	8.0%
95.09%	or Lower	10.0%

1. The formula for the Overall In Network Utilization Percentage calculation is as follows:
(The In Network Paid Claims divided by the Total Paid Claims equals the Overall In Network Utilization %).
2. In Network Utilization Guarantee applies only to eligible employees and retirees who enroll in the proposed BCBS benefit plans.
3. BCBS will exclude all claims in excess of \$100,000, claims the Employer authorizes to be paid on an exception basis, Medicare claims, claims with COB, Prescription Drug claims, Specialty Rx, claims not covered/processed by BCBS, and claims for non-contracted providers paid at the in-network level of benefits.
4. BCBS reserves the right to re-evaluate and re-establish the Guaranteed In Network Utilization Percentage if participation changes by +/- 10.0%, and/or the distribution of enrolled employees between geographic areas, the single/family mix, or age/gender composition of the group changes significantly.
5. BCBS reserves the right to void this In Network Utilization Guarantee if there are less than 3440 employees enrolled in the plan.
6. BCBS reserves the right to re-evaluate and re-establish the Guaranteed In Network Utilization Percentage if Medicare changes its payment systems during the term of this In Network Utilization Guarantee.
7. BCBS reserves the right to re-evaluate and re-establish the Guaranteed In Network Utilization Percentage if there is a change in the benefit plan design.
8. BCBS reserves the right to re-evaluate and re-establish the Guaranteed In Network Utilization Percentage if a narrow or high performance network is elected.
9. Administrative Fee at Risk will be finalized upon sale of the In Network Utilization Guarantee.
10. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, BCC, etc.
11. Any penalty paid will be dollar for dollar up to the maximum amount at risk for each tier.
12. In Network Utilization Percentage Guarantee is only valid for the quoted policy period.

*** Amount at Risk is based on current enrollment of 3,822 HCSC Primary employees. Actual amount at risk is subject to change based on final enrollment of employees who select BCBS coverage.**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association



Hidalgo County
 January 1, 2020 - December 31, 2020
 Network Discount Guarantee

Medical Claims Only
 Claims Paid 01/01/20 Through 12/31/20

Guaranteed Discount Percentage 67.5%

Actual Discounts		Admin Fee Penalty
66.50%	or Higher	0.0%
66.00%	to 66.49%	4.0%
65.50%	to 65.99%	8.0%
65.00%	to 65.49%	12.0%
64.50%	to 64.99%	16.0%
64.49%	or Lower	20.0%

1. The formula for the Overall Network Discount Percentage calculation is as follows:
 (Eligible/Covered Claims less Allowed Claims equals the Provider Savings. The Provider Savings divided by the Eligible/Covered Claims equals the Overall Network Discount %).
2. Both In-Network and Out-of-Network claims are included in the Overall Network Discount Percentage calculation.
3. Network Discount Guarantee applies only to eligible employees and retirees who enroll in the proposed BCBS benefit plans.
4. BCBS will exclude all claims in excess of \$100,000, claims the Employer authorizes to be paid on an exception basis, Medicare claims, claims with COB, Prescription Drug claims, Specialty Rx, claims not covered/processed by BCBS, and claims for non-contracted providers paid at the in-network level of benefits.
5. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if participation changes by +/- 10.0%, and/or the distribution of enrolled employees between geographic areas, the single/family mix, or age/gender composition of the group changes significantly.
6. BCBS reserves the right to void this Network Discount Guarantee if there are less than 3440 employees enrolled in the plan.
7. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if Medicare changes its payment systems during the term of this Network Discount Guarantee.
8. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if there is a change in the benefit plan design.
9. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if a narrow or high performance network is elected.
10. Discount Guarantee is based on In-Network Utilization of 98.1%. If In-Network Utilization is not met, Discount Guarantee does not apply.
11. Administrative Fee at Risk will be finalized upon sale of the Network Discount Guarantee.
12. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, BCC, etc.
13. Any penalty paid will be dollar for dollar up to the maximum amount at risk for each tier.
14. Guaranteed Discount Percentage is only valid for the quoted policy period.

***Amount at Risk is based on current enrollment of 3,822 HCSC Primary employees. Actual amount at risk is subject to change based on final enrollment of employees who select BCBS coverage.**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
 an Independent Licensee of the Blue Cross and Blue Shield Association

TAB 3

**Policy Design
Recommendations**

HIDALGO COUNTY BENEFIT PLAN CHANGES

Plan Design Changes

Basic Plan	Plan Change Options		Percent of Claim Savings	Estimated Cost	Projected Total Claim Cost
	Current	Options			
Annual Deductible	\$ 1,350	\$ 1,000	0.01	\$ 260,000	\$ 26,000,000
Maximum Out of Pocket	\$ 7,600	\$ 7,600	0	-	
Co-Insurance Percentage	70%	80%	0.008	\$ 208,000	
Co-Insurance Percentage	70%	75%	0.005	\$ 130,000	
Office Visit Co-Pay Primary Care Physician	\$ 40.00	\$ 30.00	0.005	\$ 130,000	
Office Visit Co-Pay Primary Care Physician	\$ 40.00	\$ 25.00	0.0075	\$ 195,000	
Office Visit Co-Pay Speciality Care	\$ 50.00	\$ 40.00	0.002	\$ 52,000	
Urgent Care Facility	\$ 40.00	\$ 40.00	0	-	
Emergency Room Co-Pay	\$ 350.00	\$ 350.00	0	-	
Hospital Per Admission Deductible	\$ 350.00	\$ 350.00	0	-	
Rx Co-Pays	10/20/40	10/20/40	0	-	
Step Therapy	Yes	Yes	0	-	
Mandatory Generics	Yes	Yes		-	
Diabetic Maintenance	Yes	Yes	0.004	\$ 104,000	
				\$ 715,000	

\$819,000.

TAB 4

Cost Analysis

Hidalgo County

Self-Funded Welfare Plan Stop-Loss Proposal Comparison

	Current	Renewal	United Health Care	Blue Cross
	2019	2020	2020	2020
Insurance Carrier - Third Party Administrator	Aetna	Aetna	UHC	BC
Reinsurance Carrier	Aetna	Aetna	UHC	BC
Setup Fee	\$ -	\$ -	\$ -	\$ -
Wellness Credit/ Transition credit /PBM credit		\$ 25,000	\$ 50,000	\$ 500,000
Transitional Credit			\$ 500,000	\$ 750,000
Run-In/Run-Out: Administration Fee	\$0	\$0	\$0	\$0
Terminal Liability Option Two (2) months premium estimate	\$300,000		-\$300,000	-\$300,000
Estimated run out claim liability Actuarial IBNR Reserve Estimate	\$ 2,100,000			
Specific Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
<i>* Note: These rates are not included in totals below.</i>				
STOP-LOSS BASIS				
Number of Employees	3883	3883	3883	3883
Number of Employees Only	2557	2557	2557	2557
Number of Spouse Only	122	122	122	122
Number of Child(ren) only	1052	1052	1052	1052
Number of Family	152	152	152	152
Number of Dependent Units:	1326	1326	1326	1326
Specific Deductible:	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000
Specific Contract:	Paid/12/TLO 3	Paid/12/ TLO 3	24/12	24/12
Specific Contract Includes	Med/Rx	Med/Rx	Med/Rx	Med/Rx
MONTHLY FIXED COSTS				
Specific Premium				
Employee:				
Employee and Spouse				
Employee and Child(ren)				
Dependent Unit:				
Family:				
Composite Rate Preferred	\$ 38.70	\$ 38.70	\$ 33.62	\$ 40.78
Administration(all fees per Employee per month)				
Claims Cost Per Employee :				
Claims Cost Per Dependent :				
Composite Claim per employee/month preferred	\$ 41.31	\$ 25.50	\$ 41.33	\$ 44.38
Utilization Review per Employee				
Claim Appeals Service Fee				
PPO Network Per EE:				
Rx Program Fees Annual Estimate of Dispensing/Admin fees				
Rx Rebate guarantee	\$ (26.71)	\$ (36.32)	\$ (39.58)	\$ (41.12)
Teladoc/Virtual visit Per employee Per Month	\$ 0.95			
Net Administration Fee	\$ 15.55	\$ (10.82)	\$ 1.75	\$ 3.26
Fiduciary Liability Fee	Included	Included	Included	Included
Transplant Benefit	Included	Included	Included	Included
Employee/Mth	No additional fee	No additional fee	No additional fee	No additional fee
Dependent Unit/Mth:				
Wellness Plan Cost Per EE/Mth				
Wellness Plan Cost Per EE/Mth				
Wellness Plan Credit/Pharmacy Credit	\$ 25,000	\$ 25,000	\$ 50,000	
Disease Management Per Employee Per Month	Included	Included	Included	Included
Case Management Per Employee Per Month	Included	Included	Included	Included
Banking System Notes:				
Initial Deposit/Account Requirements	None	None	\$ 591,000	None
Claim Reimbursement Requirements	Automatic	Automatic	Automatic	Automatic
Broker Fee:				
Fee	\$ 80,000	\$ 80,000	\$ 80,000	\$ 80,000
TOTAL ANNUAL COSTS				
Specific Stop Loss Premium	\$ 1,803,265	\$ 1,803,265	\$ 1,566,558	\$ 1,900,185
Administration Service fee Agent compensation (Included in Total) Includes Rebates	\$ 724,568	\$ (504,169)	\$ 81,543	\$ 151,903
TOTAL ANNUAL Including Rebates	\$ 2,527,833	\$ 1,299,096	\$ 1,648,101	\$ 2,052,088
TOTAL ANNUAL Excluding Rebates		\$ 2,991,463	\$ 3,492,370	\$ 3,968,115
Transition Credits		\$440,000	\$550,000	\$1,250,000
Net cost including credits		\$809,096	\$1,398,101	\$1,102,088

Hidalgo County

Self-Funded Welfare Plan Stop-Loss Proposal Comparison

	Aetna	United Health Care	Blue Cross
	2021	2021	2021
Insurance Carrier - Third Party Administrator	Aetna	UHC	BC
Reinsurance Carrier	Aetna	UHC	BC
Setup Fee	\$ -	\$ -	\$ -
Wellness Credit/ Transition credit /PBM credit	\$ 50,000	\$ 50,000	
Transitional Credit			
Run-In/Run-Out: Administration Fee	\$0	\$0	
Terminal Liability Option Two (2) months premium estimate			
Estimated run out claim liability Actuarial IBNR Reserve Estimate			
Specific Lifetime Maximum	Unlimited	Unlimited	Unlimited
<i>* Note: These rates are not included in totals below.</i>			
STOP-LOSS BASIS			
Number of Employees	3883	3883	3883
Number of Employees Only	2557	2557	2557
Number of Spouse Only	122	122	122
Number of Child(ren) only	1052	1052	1052
Number of Family	152	152	152
Number of Dependent Units:	1326	1326	1326
Specific Deductible:	\$ 300,000	\$ 300,000	\$ 300,000
Specific Contract:	Paid/12/ TLO 3	24/12	24/12
Specific Contract Includes	Med/Rx	Med/Rx	Med/Rx
MONTHLY FIXED COSTS			
Specific Premium			
Employee:			
Employee and Spouse			
Employee and Child(ren)			
Dependent Unit:			
Family:			
Composite Rate Preferred	\$ 44.51	\$ 38.66	\$ 46.90
Administration(all fees per Employee per month)			
Claims Cost Per Employee :			
Claims Cost Per Dependent :			
Composite Claim per employee/month preferred	\$ 26.27	\$ 42.52	\$ 42.53
Utilization Review per Employee			
Claim Appeals Service Fee			
PPO Network Per EE:			
Rx Program Fees Annual Estimate of Dispensing/Admin fees			
Rx Rebate guarantee	\$ (41.77)	\$ (40.77)	\$ (47.52)
Teladoc/Virtual visit Per employee Per Month			
Net Administration Fee	\$ (15.50)	\$ 1.75	\$ (4.99)
Fiduciary Liability Fee	Included	Included	Included
Transplant Benefit	Included	Included	Included
Employee/Mth	No additional fee	No additional fee	No additional fee
Dependent Unit/Mth:			
Wellness Plan Cost Per EE/Mth			
Wellness Plan Cost Per EE/Mth			
Wellness Plan Credit/Pharmacy Credit	\$ 50,000	\$ 50,000	
Disease Management Per Employee Per Month	Included	Included	Included
Case Management Per Employee Per Month	Included	Included	Included
Banking System Notes:			
Initial Deposit/Account Requirements	None	\$ -	None
Claim Reimbursement Requirements	Automatic	Automatic	Automatic
Broker Fee:			
Fee	\$ 80,000	\$ 80,000	\$ 80,000
TOTAL ANNUAL COSTS			
Specific Stop Loss Premium	\$ 2,073,988	\$ 1,801,401	\$ 2,185,352
Administration Service fee Agent compensation (Included in Total) Includes Rebates	\$ (722,238)	\$ 81,543	\$ (232,514)
	\$ 1,351,750	\$ 1,882,944	\$ 1,952,838
TOTAL ANNUAL Including Credits	\$ 1,301,750	\$ 1,832,944	

Stop Loss premium increase estimated 15%

TAB 5

Formulary Disruption



Formulary Analysis for COUNTY OF HIDALGO

April - July 2019

Formulary Analysis for COUNTY OF HIDALGO

Formulary Type: Advanced Control Formulary

April - July 2019

Key Statistics:

Drug Type	Rx Count	Rx %
Brands	2,271	13.6%
Generics	14,433	86.4%
Total	16,704	100.0%

Utilizing Participant Summary *

Total Eligible Members: **6,700**

Impact	Utilizers	% of Total *
Members not utilizing a drug	3,205	47.8%
Utilizing participants with no impact	3,083	46.0%
Utilizing participants with only positive impact	114	1.7%
Utilizing participants with only negative impact	285	4.3%
Utilizing participants with both positive and negative impact	13	0.2%

Negative Impact Drugs

Drugs Impacted	Members Impacted	% of Total
1	231	77.5%
2	47	15.8%
3	14	4.7%
4	4	1.3%
5+	2	0.7%
Total	298	100.0%

Formulary Impact ***

Current	Proposed	Utilizers	Rx Count	Rx %	Rx Effect **
Preferred	Preferred	534	1,232	7.4%	None
Preferred	Not Covered	166	309	1.8%	Negative
Preferred	Non-Preferred	51	68	0.4%	Negative
Non-Preferred	Preferred	125	235	1.4%	Positive
Non-Preferred	Not Covered	110	168	1.0%	Negative
Non-Preferred	Non-Preferred	156	257	1.5%	None
Generic	Not Covered	30	45	0.3%	Negative

* Percentage based on total eligible members

** Positive/Negative/None Rx Effect represents utilizing participant's benefit/loss from moving from current formulary to Aetna's formulary.

***This table excludes: Covered Generics

All Drugs with Incumbent Tier = 1 or with Aetna Standard Tier = 1 are treated as Generic.

Disruption presented is based on our current formulary and is not guaranteed for future implementation of the program. The drug list may change in the future.

Every effort is made by Aetna and its advisors to maintain the highest level of accuracy in its projections; however, because of the variability of numerous factors, which are not under the control of Aetna, we cannot guarantee the estimated results.

Formulary Analysis for COUNTY OF HIDALGO

Formulary Type: Advanced Control Formulary

April - July 2019

Key Statistics

Drug Type	Rx Count	Rx %
Brands	2,271	13.6%
Generics	14,433	86.4%
Total	16,704	100.0%

Drug Detail for Brands and Excluded Generics

Drug Name	Current Tier	Proposed Tier	Util Count	Rx Count	Rx % *	Notes
TRULICITY	2	2	65	148	0.89%	
TRESIBA FLEXTOUCH	2	2	45	79	0.47%	
SYNTHROID	3	3	31	75	0.45%	
JANUMET	2	2	37	67	0.40%	
JANUVIA	2	2	39	66	0.40%	
JARDIANCE	2	2	35	64	0.38%	
INVOKANA	2	X	30	61	0.37%	
FARXIGA	2	2	32	59	0.35%	
VYVANSE	2	2	25	57	0.34%	
LO LOESTRIN FE	3	2	25	53	0.32%	
VICTOZA	2	2	30	51	0.31%	
HUMALOG KWIKPEN	2	X	23	42	0.25%	
VASCEPA	2	X	25	37	0.22%	
SYMBICORT	2	2	28	35	0.21%	
LINZESS	2	2	20	34	0.20%	
CIPRODEX	2	2	33	34	0.20%	
LEVEMIR FLEXTOUCH	2	2	17	33	0.20%	
PROAIR HFA	2	2	27	29	0.17%	
LOTEMAX	2	2	18	26	0.16%	
OZEMPIC	3	2	11	25	0.15%	
FREESTYLE LITE TEST STRIP	2	X	22	24	0.14%	
NUVARING	2	2	8	24	0.14%	
BASAGLAR KWIKPEN	2	2	15	23	0.14%	
JANUMET XR	2	2	12	23	0.14%	
BREO ELLIPTA	2	2	14	23	0.14%	
LYRICA	2	2	12	23	0.14%	
XIGDUO XR	2	2	12	22	0.13%	
B D PEN NEEDLE/NANO/ULTRA	2	2	16	21	0.13%	
HUMIRA PEN	3	2	7	20	0.12%	
HUMALOG MIX 75/25 KWIKPEN	2	X	12	18	0.11%	
SYNJARDY XR	2	2	10	18	0.11%	
PAZEO	3	2	16	18	0.11%	
BYSTOLIC	3	X	8	16	0.10%	
INVOKAMET	2	X	9	16	0.10%	
SYNJARDY	2	2	9	16	0.10%	
H-E-B IN CONTROL PEN NEED	3	X	13	16	0.10%	
FREESTYLE LANCETS	2	3	14	14	0.08%	
PREMARIN	2	2	8	14	0.08%	
ENBREL SURECLICK	2	2	5	14	0.08%	Coverage Based on Indication
XIIDRA	2	2	9	14	0.08%	
ADVAIR HFA	3	2	9	13	0.08%	
SOLIQUA 100/33	2	2	8	13	0.08%	
MOVIPREP	3	X	13	13	0.08%	
BUTALBITAL/ACETAMINOPHEN/	1	X	9	12	0.07%	
XULTOPHY 100/3.6	2	3	7	12	0.07%	
ONETOUCH ULTRA BLUE	2	X	8	12	0.07%	
TRADJENTA	2	X	10	12	0.07%	
HUMALOG	2	X	6	12	0.07%	
GLYXAMBI	2	2	7	12	0.07%	
ONETOUCH VERIO TEST STRIP	2	X	6	11	0.07%	
TRUVADA	2	2	3	11	0.07%	
SHINGRIX	3	3	9	11	0.07%	
COSENTYX SENSOREADY PEN	3	2	3	10	0.06%	Coverage Based on Indication
XARELTO	2	2	6	10	0.06%	

Drug Name	Current Tier	Proposed Tier	Util Count	Rx Count	Rx % *	Notes
BOOSTRIX	3	3	10	10	0.06%	
M-M-R II	3	3	10	10	0.06%	
OTEZLA	2	2	2	9	0.05%	
RESTASIS	2	X	7	9	0.05%	
CITRANATAL ASSURE	3	2	4	9	0.05%	
DULERA	2	X	6	9	0.05%	
VITAFOL-OB+DHA	2	3	4	9	0.05%	
MYRBETRIQ	2	2	4	9	0.05%	
VIMPAT	3	2	2	8	0.05%	
AIMOVIG	3	X	3	8	0.05%	
FLOVENT HFA	3	X	5	8	0.05%	
ENTRESTO	2	2	5	8	0.05%	
LEVEMIR	2	2	4	8	0.05%	
FREESTYLE LITE TEST STRIP	3	X	8	8	0.05%	
EPIDUO FORTE	2	2	8	8	0.05%	
ARMOUR THYROID	3	3	4	7	0.04%	
TOUJEO SOLOSTAR	3	X	5	7	0.04%	
HUMULIN N	2	X	2	7	0.04%	
CARAFATE	3	X	5	7	0.04%	
BRILINTA	2	2	3	7	0.04%	
TRIUMEQ	2	2	2	6	0.04%	
SIMPONI	2	2	3	6	0.04%	Coverage Based on Indication
ONETOUCH DELICA LANCETS F	2	3	3	6	0.04%	
FENOFIBRATE	1	X	4	6	0.04%	
PROAIR RESPICLICK	2	2	5	6	0.04%	
OZEMPIC	2	2	6	6	0.04%	
AURYXIA	3	3	5	6	0.04%	
NOVOFINE 32GX6MM	3	X	6	6	0.04%	
NATURE-THYROID	3	3	2	6	0.04%	
ALPHAGAN P	3	2	1	6	0.04%	
MIRENA	3	2	6	6	0.04%	
ELIQUIS	2	2	5	6	0.04%	
TRUEPLUS LANCETS 33G	2	3	6	6	0.04%	
ULORIC	3	X	3	5	0.03%	
TROKENDI XR	3	2	1	5	0.03%	
AMITIZA	3	2	4	5	0.03%	
ULTICARE MICRO PEN NEEDLE	3	X	5	5	0.03%	
REVLIMID	3	2	1	5	0.03%	
FINACEA	3	2	4	5	0.03%	
ONETOUCH DELICA LANCETS E	2	3	5	5	0.03%	
INVOKAMET XR	2	X	2	5	0.03%	
SELECT-OB+DHA	3	3	2	5	0.03%	
MENVEO	3	3	5	5	0.03%	
ENBREL	2	2	2	5	0.03%	Coverage Based on Indication
XOFLUZA	3	X	5	5	0.03%	
DUREZOL	2	X	3	4	0.02%	
HUMULIN R U-500 KWIKPEN	2	2	1	4	0.02%	
TIVICAY	2	2	1	4	0.02%	
HUMALOG MIX 75/25	2	X	1	4	0.02%	
DILTIAZEM HCL ER	1	X	1	4	0.02%	
TRAVATAN Z	2	2	2	4	0.02%	
SKLICE	3	3	4	4	0.02%	
SEROQUEL XR	3	X	1	4	0.02%	
SAPHRIS	3	3	1	4	0.02%	
RYTARY	3	3	1	4	0.02%	
ICLUSIG	3	3	1	4	0.02%	
B D ALCOHOL SWABS SINGLE USE	3	3	2	4	0.02%	
QVAR REDHALER	2	2	4	4	0.02%	
PREVNAR 13	3	3	4	4	0.02%	
AZOPT	2	2	2	4	0.02%	
CITRANATAL 90 DHA	3	2	3	4	0.02%	
ADACEL	3	3	4	4	0.02%	
VARIVAX	3	3	3	4	0.02%	
CREON	2	2	1	4	0.02%	
NUVESSA	3	X	4	4	0.02%	
NUEDEXTA	2	3	1	4	0.02%	
ANTARA	3	3	2	4	0.02%	
VENLAFAXINE HCL ER	1	X	1	4	0.02%	

Drug Name	Current Tier	Proposed Tier	Util Count	Rx Count	Rx % *	Notes
AUBAGIO	2	2	1	4	0.02%	
ENVARUS XR	3	X	1	4	0.02%	
CABOMETYX	2	2	1	4	0.02%	
ENSTILAR	3	3	3	4	0.02%	
ANORO ELLIPTA	2	2	1	4	0.02%	
LIVALO	3	X	1	4	0.02%	
EMSAM	3	3	1	4	0.02%	
XELJANZ XR	2	2	1	4	0.02%	Coverage Based on Indication
KOMBIGLYZE XR	3	X	3	4	0.02%	
XELJANZ	2	2	1	4	0.02%	Coverage Based on Indication
DILANTIN	2	X	1	4	0.02%	
VITAFOL ULTRA	3	3	3	4	0.02%	
HUMULIN R	2	X	2	4	0.02%	
JENTADUETO XR	2	X	4	4	0.02%	
ARNUITY ELLIPTA	3	2	3	4	0.02%	
VENTOLIN HFA	2	X	3	3	0.02%	
INSULIN LISPRO KWIKPEN	1	X	3	3	0.02%	
TRINTELLIX	3	2	2	3	0.02%	
SPIRIVA HANDIHALER	2	2	1	3	0.02%	
GNP ALCOHOL SWABS	3	3	1	3	0.02%	
B D PEN NEEDLE U/F III MI	2	2	3	3	0.02%	
REMICADE	2	2	1	3	0.02%	
COMBIGAN	2	2	2	3	0.02%	
DOVATO	3	X	1	3	0.02%	
OXYCONTIN	2	2	1	3	0.02%	
OTREXUP	3	X	1	3	0.02%	
NAPROXEN	1	X	3	3	0.02%	
MENACTRA	2	3	3	3	0.02%	ACA Product
ABSORICA	3	3	1	3	0.02%	
LUPRON DEPOT (1-MONTH)	3	3	1	3	0.02%	
SPIRIVA RESPIMAT	2	2	2	3	0.02%	
ALOGLIPTIN/PIOGLITAZONE	1	X	2	3	0.02%	
KRISTALOSE	3	3	3	3	0.02%	
ZENPEP	2	2	1	3	0.02%	
JULUCA	3	3	1	3	0.02%	
XIFAXAN	2	2	1	3	0.02%	
JENTADUETO	2	X	3	3	0.02%	
DYMISTA	3	2	1	3	0.02%	
DYMISTA	2	2	2	3	0.02%	
VITAFOL-ONE	3	3	1	3	0.02%	
ZOMIG	3	2	1	3	0.02%	
INTRAROSA	3	3	2	2	0.01%	
INSULIN LISPRO	1	X	1	2	0.01%	
BEPREVE	3	X	2	2	0.01%	
TRULANCE	2	3	2	2	0.01%	
TOBREX	3	3	2	2	0.01%	
TRUEPLUS INSULIN SYRINGE/	3	X	1	2	0.01%	
HUMULIN 70/30 KWIKPEN	2	X	1	2	0.01%	
BELSOMRA	3	X	1	2	0.01%	
TRANSDERM-SCOP	3	3	2	2	0.01%	
ALOGLIPTIN	1	X	2	2	0.01%	
DICLEGIS	3	3	1	2	0.01%	
DEXILANT	3	2	1	2	0.01%	
TOBRADEX	3	2	2	2	0.01%	
TAYTULLA	3	X	2	2	0.01%	
B D PEN NEEDLES ULTRAFINE	2	2	2	2	0.01%	
DENAVIR	3	X	1	2	0.01%	
SURE COMFORT PEN NEEDLES	3	X	1	2	0.01%	
DAYTRANA	3	3	1	2	0.01%	
GYNAZOLE-1	3	3	2	2	0.01%	
SM ALCOHOL PREP PADS	3	3	2	2	0.01%	
SKYLA	3	2	2	2	0.01%	
GLOBAL EASE INJECT PEN NE	3	X	2	2	0.01%	
GLOBAL ALCOHOL PREP EASE	3	3	2	2	0.01%	
GARDASIL 9	3	3	2	2	0.01%	
FREESTYLE TEST STRIPS	2	X	2	2	0.01%	
CLEVER CHOICE COMFORT EZ	3	X	1	2	0.01%	
FREESTYLE PRECISION NEO B	2	X	2	2	0.01%	

Drug Name	Current Tier	Proposed Tier	Util Count	Rx Count	Rx % *	Notes
PROLENSA	3	2	1	2	0.01%	
FREESTYLE LANCETS	3	3	2	2	0.01%	
PREMPRO	2	2	1	2	0.01%	
BESIVANCE	3	2	2	2	0.01%	
PNEUMOVAX 23	2	3	2	2	0.01%	ACA Product
PARAGARD INTRAUTERINE COP	3	3	2	2	0.01%	
FLOVENT DISKUS	3	X	2	2	0.01%	
ALREX	2	2	2	2	0.01%	
CIMZIA	3	3	1	2	0.01%	Exclusion with Grandfathering
CHANTIX STARTING MONTH PA	3	3	2	2	0.01%	
FC2 FEMALE CONDOM	X	3	2	2	0.01%	
NOVOLOG MIX 70/30 PREFILL	3	2	1	2	0.01%	
NOVOFINE PLUS 32GX4MM	3	X	1	2	0.01%	
CHANTIX	3	3	2	2	0.01%	
NEXPLANON	3	3	2	2	0.01%	
ASMANEX TWISTHALER 30 MET	2	2	1	2	0.01%	
METFORMIN HYDROCHLORIDE E	1	X	1	2	0.01%	
ENGERIX-B	3	3	2	2	0.01%	
EMVERM	3	3	2	2	0.01%	
BYDUREON BCISE	3	X	1	2	0.01%	
VYVANSE	2	2	2	2	0.01%	
VRAYLAR	3	2	1	2	0.01%	
ALOGLIPTIN/METFORMIN HCL	1	X	1	2	0.01%	
DYANAVAL XR	3	3	2	2	0.01%	
VESICARE	3	2	1	2	0.01%	
VELPHORO	3	2	1	1	0.01%	
VAQTA	3	3	1	1	0.01%	
UNIFINE PENTIPS 31G X 3/1	3	X	1	1	0.01%	
ULTRA-CARE LANCETS 30G	3	3	1	1	0.01%	
ULTICARE MINI PEN NEEDLES	3	X	1	1	0.01%	
TRUEPLUS PEN NEEDLES 32GX	3	X	1	1	0.01%	
TRUEPLUS LANCETS 30G	2	3	1	1	0.01%	
TRUEPLUS LANCETS 28G	2	3	1	1	0.01%	
DIFLORASONE DIACETATE	1	X	1	1	0.01%	
HUMULIN 70/30	2	X	1	1	0.01%	
HUMIRA PEN-CD/UC/HS START	3	2	1	1	0.01%	
TOUJEO MAX SOLOSTAR	3	X	1	1	0.01%	
HUMIRA	3	2	1	1	0.01%	
TALTZ	3	2	1	1	0.01%	Coverage Based on Indication
DESONATE	3	3	1	1	0.01%	
HUMALOG MIX 50/50 KWIKPEN	2	X	1	1	0.01%	
SYNERA	3	3	1	1	0.01%	
SURE COMFORT LANCETS 30G	3	3	1	1	0.01%	
SUPRAX	3	2	1	1	0.01%	
HM STERILE ALCOHOL PREP P	3	3	1	1	0.01%	
STIMATE	3	3	1	1	0.01%	
CYCLOSET	3	3	1	1	0.01%	
SOOLANTRA	3	3	1	1	0.01%	
GLUCAGON EMERGENCY KIT	2	2	1	1	0.01%	
QUFLORA GUMMIES	3	X	1	1	0.01%	
QBREXZA	3	X	1	1	0.01%	
PROLIA	3	2	1	1	0.01%	
INVELTYS	3	X	1	1	0.01%	
PLENVU	3	X	1	1	0.01%	
FORTEO	3	2	1	1	0.01%	
PAXIL CR	3	X	1	1	0.01%	
FLUOXETINE HYDROCHLORIDE	1	X	1	1	0.01%	
AZASAN	3	3	1	1	0.01%	
FLAREX	3	3	1	1	0.01%	
OSPHENA	3	2	1	1	0.01%	
CIALIS	2	3	1	1	0.01%	
FIASP	3	2	1	1	0.01%	
OCALIVA	3	3	1	1	0.01%	
EVAMIST	3	2	1	1	0.01%	
NITRO-BID	3	3	1	1	0.01%	
EPIPEN 2-PAK	3	2	1	1	0.01%	
NATROBA	3	3	1	1	0.01%	
MOTEGRITY	3	X	1	1	0.01%	

Drug Name	Current Tier	Proposed Tier	Util Count	Rx Count	Rx % *	Notes
MICROLET LANCETS COLORED	2	3	1	1	0.01%	
BYDUREON PEN	3	X	1	1	0.01%	
LUPRON DEPOT (3-MONTH)	3	3	1	1	0.01%	
ASMANEX TWISTHALER 14 MET	2	2	1	1	0.01%	
LORTAB	3	3	1	1	0.01%	
LIPOFEN	3	3	1	1	0.01%	
EDARBI	3	X	1	1	0.01%	
LASTACAFT	3	X	1	1	0.01%	
ZYLET	3	2	1	1	0.01%	
ASMANEX HFA	2	2	1	1	0.01%	
EASY COMFORT PEN NEEDLES	3	X	1	1	0.01%	
LANCETS ULTRA THIN	3	3	1	1	0.01%	
ZIRGAN	3	3	1	1	0.01%	
EASY COMFORT LANCETS	2	3	1	1	0.01%	
LANTUS SOLOSTAR	3	X	1	1	0.01%	
ACZONE	3	3	1	1	0.01%	
ADVAIR DISKUS	3	2	1	1	0.01%	
EASY COMFORT INSULIN SYRI	3	X	1	1	0.01%	
VIIBRYD	3	2	1	1	0.01%	
VIBERZI	2	2	1	1	0.01%	

* % of all prescriptions

***This table excludes: Covered Generics

The New to Market (NTM) Block list changes frequently and is likely to change prior to implementation



Formulary Analysis for COUNTY OF HIDALGO

Formulary Type: Advanced Control Formulary

April - July 2019

Details for All Other Specialty Formulary Exclusions (Except Autoimmune Agents)

Drug Name	Indications/Use or Action	Util Count	Rx Count	Rx % *	Standard Exclusion	ACSF Exclusion	Grandfathered	Alternatives**
OTREXUP	Antineoplastic Agents	1	3	0.02%	N	Y	N	RASUVO

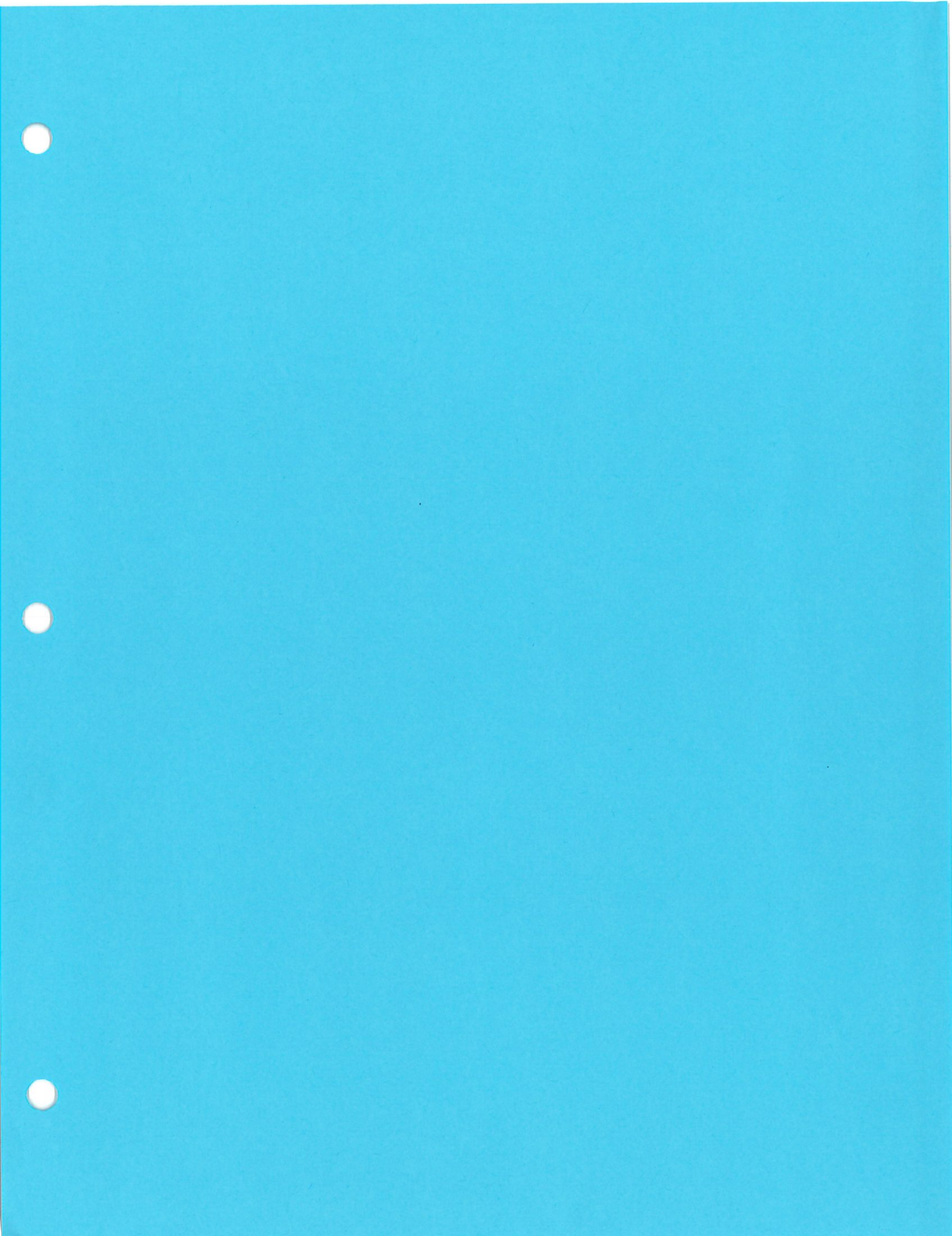
* % of all drugs

** Alternatives are subject to change based on future formulary announcements

*** Within each drug name, some doses and strengths may not be considered Multi-Source Brand (MSB) even if the drug is flagged as a MSB

This table does not include specialty exclusions due to a New to Market Block

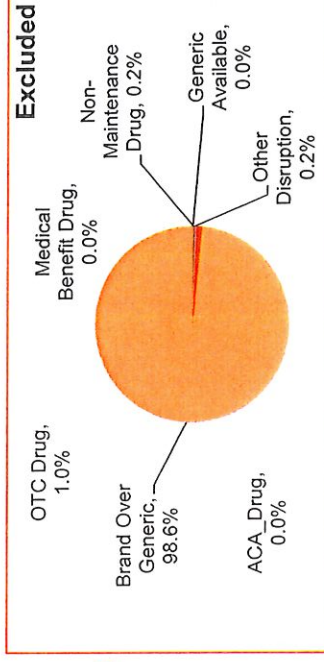
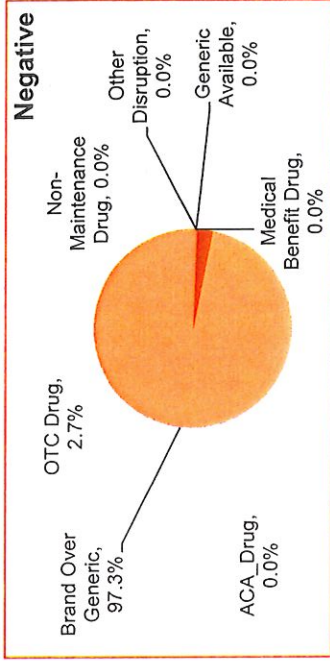
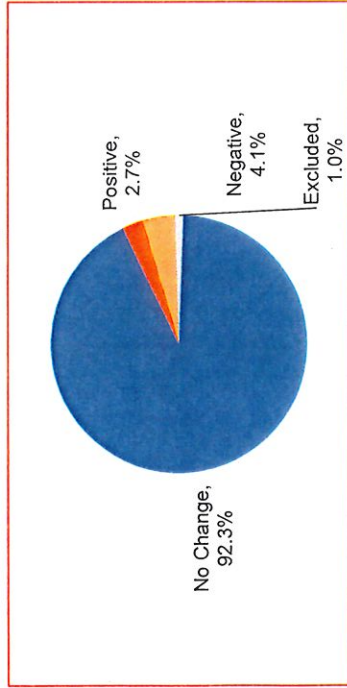




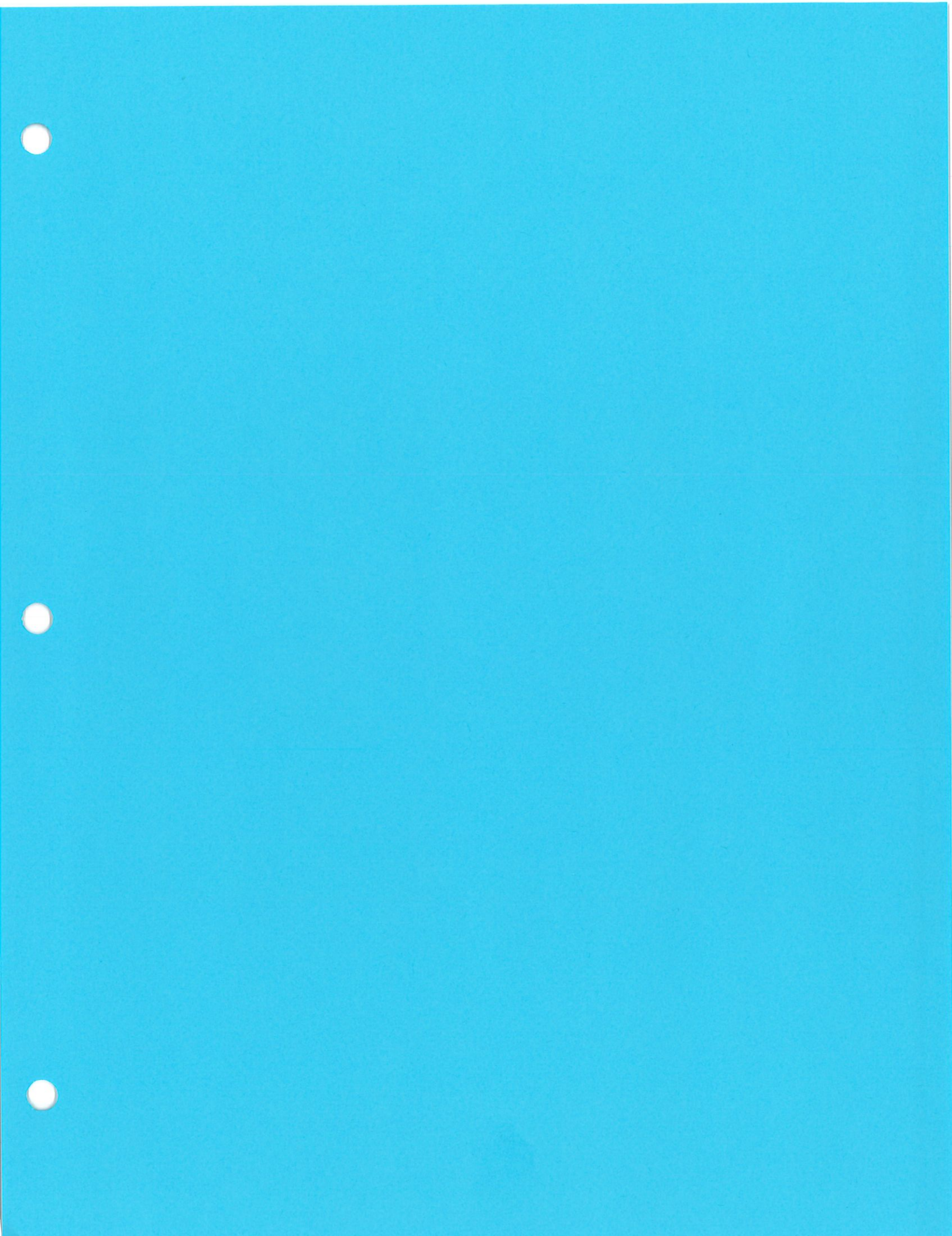
Hidalgo County
Claims Period: Jan 2018 - Dec 2018
Formulary Disruption - Flex

Type of Change	Rxs	% of Total Rxs
No Change	46,280	92.3%
Positive	1,333	2.7%
Negative	2,066	4.1%
Excluded	484	1.0%
Total	50,163	100.0%

Percent of Rxs



Notes
OptumRx formulary as of Aug 1 2019
582 Claim(s) could not be assigned a tier
Excluded drugs are not covered on the formulary



BCBSTX
Hidalgo County
Based on claims from 10/1/18 - 12/31/18
Formulary Disruption Summary
Prime Formulary Status Based on the Basic Formulary as of 9/20/2019

Disruption Type	# of Claims	% Rx
No Disruption	6,916	95.5%
Positive Tier Change	83	1.1%
Negative Tier Change	240	3.3%
Excluded; Non-FDA	0	0.0%
TOTAL	7,239	

**Disruption looks at the most recent 4 months of claims only*

**Positive/Negative Tier Change based on brand drugs only*

**Exclusions are Non-FDA Drugs Only*

**Any claim reversals removed from the analysis*

**Unidentified NDC's removed from the analysis*

**Any non-maintenance medications removed from the analysis*

Appendix

Proposed Premiums

Gap Insurance (Examples)

HIDALGO COUNTY
DBM Proposed Health Insurance Premiums 2020
6% Increase

BASIC	Monthly Premium		Employee Cost		
	Current	2020 Proposed	Current (Monthly)	2020 Proposed (Monthly)	Increase Per Pay Period
Employee Only	\$ 616.00	\$ 654.00	\$ -	\$ -	\$ -
Employee + Spouse	\$ 1,026.00	\$ 1,088.00	\$ 410.00	\$ 434.00	\$ 12.00
Employee + Child(ren)	\$ 732.00	\$ 776.00	\$ 116.00	\$ 122.00	\$ 3.00
Employee + Family	\$ 1,144.00	\$ 1,214.00	\$ 528.00	\$ 560.00	\$ 16.00

BUY-UP	Monthly Premium		Employee Cost		
	Current	2020 Proposed	Current (Monthly)	2020 Proposed (Monthly)	Increase Per Pay Period
Employee Only	\$ 788.00	\$ 836.00	\$ 172.00	\$ 182.00	\$ 5.00
Employee + Spouse	\$ 1,372.00	\$ 1,454.00	\$ 756.00	\$ 800.00	\$ 22.00
Employee + Child(ren)	\$ 966.00	\$ 1,024.00	\$ 350.00	\$ 370.00	\$ 10.00
Employee + Family	\$ 1,604.00	\$ 1,700.00	\$ 988.00	\$ 1,046.00	\$ 29.00

RETIREE under 65	Monthly Premium	
	Current	2020 Proposed
Employee Only	\$ 562.00	\$ 596.00
Employee + Spouse	\$ 974.00	\$ 1,032.00
Employee + Child(ren)	\$ 678.00	\$ 720.00
Employee + Family	\$ 1,090.00	\$ 1,156.00

RETIREE 65 & over	Monthly Premium	
	Current	2020 Proposed
Employee Only	\$ 284.00	\$ 302.00
Employee + Spouse	\$ 696.00	\$ 738.00
Employee + Child(ren)	\$ 402.00	\$ 426.00
Employee + Family	\$ 812.00	\$ 862.00

*Proposed County Portion is \$654.00 per month or \$327.00 per pay period (increase of \$19.00 per pay period)



Proposal for:
 Class: ALL EMPLOYEES
 Prepared by: Beazley Insurance Company, Inc.
 Contact: sales@beazleybenefits.com; (877)503-5234
 Date of Issue: 06/27/2019 Effective Date: 09/01/2019

Schedule of Benefits

Supplemental Medical Expense (Voluntary)	
Plan features	Benefit options
Plan Design	Guarantee Issue
Eligibility	Employee Status: All Permanent Employees Employee Hours: Working 30 hours or more per week and actively in service
Early Retiree Eligibility	No
Inpatient Hospital Benefit*	Benefit Year Maximum per Insured: \$1,000
Outpatient Hospital Standard Benefit*	Benefit Year Maximum per Insured: \$500
Outpatient Hospital Rider Benefit*	Physician Office/Urgent Care benefit plus Chemo/Radiation Therapy benefit included in Standard Benefit maximum stated above.
Family Maximum Limit	2 times Individual Benefit Amount
Termination	Unlimited Age for Active Employees
Rate Guarantee	12 Months

* For definitions of Underwriting options, refer to Rates and Assumptions page. For full description, please request the Master Policy definitions from the agent/broker.



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Rates and Assumptions

Supplemental Medical Expense (Voluntary)

Age	Employee Rates	Employee & Spouse Rates	Employee & Child (ren) Rates	Family Rates
18 - 49	\$27.68	\$59.51	\$48.44	\$87.19
50 - 99	\$50.09	\$107.69	\$75.14	\$137.75

Key Assumptions:

- Rates shown above are expressed monthly.
- Coverage is available to groups with a minimum of 10 eligible lives.
- Coverage is contingent on satisfying participation requirements as follows: groups with 10-19 eligible employees require a minimum of 8 covered employees; groups with 20-49 eligible employees require a minimum of 12 covered employees; groups with 50-99 eligible employees require a minimum of 15 covered employees; and groups with 100+ eligible employees require a minimum of 15% participation.
- A material change in group demographics or assumptions will require a recalculation of rates and terms.
- Late entrants are eligible to enter the program, as of the next anniversary date.
- Coverage requires existence of underlying major medical program.
- Coverage varies, depending on individual state law requirements and may be unavailable in some states.
- Coverage is subject to and governed by the terms and conditions of each policy issued.
- Certain standard exclusions and limitations may apply.
- Quote is valid for 90 days.
- This proposal is confidential between Beazley and the agent and prospect.



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Schedule of Benefits

Supplemental Medical Expense (Voluntary)	
Plan features	Benefit options
Plan Design	Guarantee Issue
Eligibility	Employee Status: All Permanent Employees Employee Hours: Working 30 hours or more per week and actively in service
Early Retiree Eligibility	No
Inpatient Hospital Benefit*	Benefit Year Maximum per Insured: \$3,500
Outpatient Hospital Standard Benefit*	Benefit Year Maximum per Insured: \$2,000
Outpatient Hospital Rider Benefit*	Physician Office/Urgent Care benefit plus Chemo/Radiation Therapy benefit included in Standard Benefit maximum stated above.
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Rates and Assumptions

Supplemental Medical Expense (Voluntary)

Age	Employee Rates	Employee & Spouse Rates	Employee & Child (ren) Rates	Family Rates
18 - 49	\$57.91	\$124.51	\$101.34	\$182.42
50 - 99	\$105.10	\$225.97	\$157.65	\$289.03

Key Assumptions:

- Rates shown above are expressed monthly.
- Coverage is available to groups with a minimum of 10 eligible lives.
- Coverage is contingent on satisfying participation requirements as follows: groups with 10-19 eligible employees require a minimum of 8 covered employees; groups with 20-49 eligible employees require a minimum of 12 covered employees; groups with 50-99 eligible employees require a minimum of 15 covered employees; and groups with 100+ eligible employees require a minimum of 15% participation.
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