TAP / CITY OF CHICAGO / OCTOBER 7, 2026

Better care. A stronger financial equation.

A 24/7 employee care proposal for the City of Chicago

Prepared for the Deputy Mayor and the Benefits and Labor teams. TAP gives employee households a direct connection to a clinical team by text, photo, phone or video—before an everyday health concern becomes a higher-cost claim.

$40.05 million projected gross savings annually
$29.25 million after $10.8 million in annual TAP fees
Previously shared base model: **3.71× gross return on TAP fees · 270.82% net ROI**.

At **$9 per employee per month ($108 annually)**, the prior model projects **$400.48 in annual gross plan savings per employee and $292.48 after TAP fees**. It assumes 100,000 employees and 250,000 covered lives; those counts are planning assumptions, not a validated City census. Figures exclude unentered additional costs and assume the City retains all avoided plan spending. [4]

The decision for this meeting
Name Benefits, Finance and Labor sponsors to turn the existing savings model into a defined workforce program: validate the census and plan economics, agree on written terms and establish a measurable launch decision. Employee use would be voluntary; existing benefits remain in place.

What employees and households receive

A direct number for text, photos, phone or video with a licensed physician, physician assistant or nurse practitioner, as clinically appropriate. For the proposed Chicago employee program, TAP would provide **24/7 coverage: 24 hours a day, seven days a week**. TAP-delivered care carries no TAP copay and no insurance claim submitted by TAP. Household access is independent of City health-plan enrollment, subject to agreed eligibility. [1]

Public employers. Whole communities.

TX Health Benefits Pool: more than 700 member entities. TAP is phasing in through the pool as groups renew; this footprint overlaps with TAP's reported reach of 800+ cities and special districts, not 800 separate contracts. [4,5]
Algonquin, Illinois: an established resident program reaches enrolled utility households. Separately, TAP reports over 70% staff use in the first eight months. [4,5]
Chesterfield County, SC: official sources confirm resident access. TAP reports **15,000+ patient encounters in the first 18 months**; encounters are not unique patients or audited savings. These are operating examples, not Chicago savings results. [5]

Existing coverage and primary-care relationships remain in place. Medicines, tests, imaging and outside care may generate separate charges or claims. TAP is not emergency care, does not prescribe controlled substances and does not replace necessary in-person evaluation. For emergencies, call 911. [1]

The model already shared with Chicago

The base case projects **$40,048,450 in annual gross plan savings** from clinically appropriate substitution for emergency-department and urgent-care visits. After **$10,800,000 in TAP fees**, the modeled value is **$29,248,450**. This is the starting case for joint validation—not demonstrated Chicago savings. [4]

Annual result	Lower	Base	Higher
Gross modeled plan savings	$30.77M	$40.05M	$56.30M
TAP investment	$10.80M	$10.80M	$10.80M
Value after TAP fees	**$19.97M**	**$29.25M**	**$45.50M**
Gross savings / TAP fees	2.85×	3.71×	5.21×
Net ROI after TAP fees	**184.94%**	**270.82%**	**421.28%**
Modeled ED + urgent-care visits replaced	59,190	87,738	124,833

All scenarios: 100,000 employees, 250,000 covered lives, $9 per employee monthly. “Value after TAP fees” excludes unentered implementation, evaluation and downstream costs. The prior model assumes 100% of avoided plan costs is retained. Lower/base/higher reflect scenario assumptions, not statistical confidence limits. [4]

Where the base-case dollars come from

Emergency care: 250,000 lives × 0.473 annual visits × 25% low acuity × 60% diversion = 17,737.5 modeled visits replaced. At $1,804 assumed plan-paid cost per visit: **$31,998,450**.
Urgent care: 250,000 lives × 0.7 annual visits × 40% diversion = 70,000 visits. At $115 assumed plan-paid cost: **$8,050,000**. Together: **$40,048,450**. [4]

The employee-level equation
$108 annual TAP investment → $400.48 modeled gross savings → **$292.48 after fees; 270.82% net ROI**.
Break-even is $108 retained savings per employee annually before additional costs.

Net City value = attributable avoided plan costs × City-retained share − TAP fees − other incremental costs. **Net ROI** = net City value ÷ total program cost. Each additional dollar of cost reduces net value; existing telehealth substitution, new utilization and downstream spending must be reconciled once.

Chicago’s FY2025 audited report describes a **self-insured PPO and partially insured HMO**, plus obligations for certain eligible retirees. Validate plan-paid claims, stop-loss effects and any premium or credit mechanism by funding segment. Retirees need separate eligibility, pricing and analysis; household savings outside the City plan are not City plan savings. [3]

Explore the model online: adjust employee count, household size, fee, retained savings and additional costs.

Fit with the City's existing benefits

Chicago already covers telehealth. Its 2026 Group A and B HMO booklets list $25 general and $35 specialist telehealth visits, subject to plan rules. Compare TAP alongside Blue Choice Options PPO and Blue Advantage HMO; confirm implementation-year benefits, including 2027 changes. No carrier approval is implied. [2]

Before contracting	What the City and TAP should resolve
Eligibility and access	Who can use each service? Confirm household definition, minors, locations served and exclusions. Compare steps to start care, hours, language assistance, accessibility and phone alternatives.
Incremental value	Identify gaps and duplicated services. Validate value with claims as well as uptake and employee experience. Obtain the incumbent's actual utilization and service data.
Clinical integration	Confirm HMO PCP/referral and network rules, PBM/formulary fit, any steering restrictions, escalation, response commitments and staffing capacity.

Proposed employee assurances

Employer-funded access with **no employee payroll deduction for TAP** and voluntary use. No replacement of negotiated coverage, no change to leave rules, and no requirement to contact TAP before using sick leave or other covered care. Individual use or clinical information would not be used for attendance, performance or employment decisions. Benefits and Labor should approve employee and union-facing communications together.

A timely reminder through the timekeeping system

Proposed integration: when an employee records a sick day, show a neutral reminder that TAP is available. Include a phone option and accessible, multilingual support for all shifts. The reminder does not change leave approval or send symptoms, clinical details or TAP usage back to HR. Benefits, Labor, IT and privacy teams must approve the workflow before activation.

Privacy and clear ownership

TAP operates care and support; HR manages eligibility and communications. City reporting should be aggregate, with small-cell protections. Security review should cover data flows, access controls, incident handling and required agreements.

City Benefits, Finance and plan administrator: confirm census, funding segments, baseline data, overlap and retained savings.
City Labor, legal, procurement and security: review employee assurances, communications, contracting path and data protections.
TAP: provide service scope, capacity plan, eligibility workflow, support ownership, reporting definitions and final terms.

Measurement and the next decision

Before launch: start with existing aggregate plan reports. Benefits and Finance should own evaluation with the plan administrator. Where needed, request 24 months of de-identified claims, monthly eligibility, funding/stop-loss terms, telehealth use and net PBM costs. Use a City-approved secure process and minimum necessary data.

Checkpoint	What should be established
First 30 days after joint kickoff	Reconcile scope and price; map existing benefits; progress labor, procurement and security review; assign department/shift communications and support. A proposed work plan, not a guaranteed launch deadline.
90 days after launch	Review eligible and activated households, unique users, access and response times, repeat use, escalations, complaints and employee experience. Show denominators and missing data. This is an operational review.
6–12 months after launch plus claims runout	Assess plan-paid costs against a pre-agreed risk- and trend-adjusted comparison. Address seasonality, selection, workforce changes, existing-care substitution and downstream costs. City/administrator validates net savings.

Written terms must settle billable employees and reconciliation, household eligibility, service and response commitments, all fees, reporting and data rights, implementation duties, and termination/transition terms. TAP's featured offer includes a 30-day exit; notice, applicability and financial consequences must be confirmed in the Chicago agreement. Approve a maximum program spend and a continue, adjust or stop decision rule. No guaranteed ROI or accepted City price is established here. [1]

The larger vision

Extend care to **all uninsured Chicago households**, funded by verified employee-program savings. First establish recurring net savings after all costs and a prudent reserve. Households supportable for one year = approved annual funding ÷ all-in annual household price, rounded down. Validate the uninsured-household count, unit price and funding durability; any shortfall needs another funding source. This is a separate City decision, not a promised outcome.

Next step: name Benefits, Finance and Labor sponsors; agree with TAP and the plan administrator on scope, data, a spending ceiling and a decision date. Return with a written quote and validated break-even analysis before launch.

Sources and accompanying materials

[1] TAP employer offer and HR films, reviewed Oct 6, 2026. TAP confirmed Chicago 24/7 coverage Oct 6. Final employer agreement governs terms.
[2] City medical materials, 2026 Group A/B HMO booklets, p.5; BCBSIL 2026 guide. Plan rules apply.
[3] City FY2025 audited report, pp.100–104: retiree benefits and funding.
[4] TAP records: staff adoption Aug 27; entity-count clarification Oct 2; TXHB transition Jan 8–9, 2026. Usage is TAP-reported; confirm denominator before comparisons. Earlier Chicago proposal and prior one-page model contain historical assumptions, not City results.
[5] Official sources: TXHB membership; Algonquin household program; Chesterfield resident access. Availability is not universal participation. TAP Chesterfield case study: company-reported encounters. Evidence and film.