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STATE EMPLOYEES HEALTH CARE COMMISSION

QUARTERLY MEETING

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>> CHAIR PROFFITT: Very good. Good morning, everybody, we will go ahead and call today's Health Care Commission meeting to order. February 16, 2024. We'll take roll.

>> VICKI SCHMIDT: Here.

>> CHAIR PROFFITT: Commissioner Dechant? What I'm hearing he is online, we are working on technical difficulties to allow him to speak. We will let the minutes reflect he is there and will continue to work. Commissioner Kane.

>> CRISTI CAIN: Here.

>> CHAIR PROFFITT: Here and chair is here. We have a quorum. So we will go ahead and get moving. I think our legislative members might have legislative commitments this morning, we'll keep an eye out to see if and when they join. Commissioners, your packets were e‑mailed to you earlier ethics week or late last week. In there were the minutes. First item review the minutes. Are there any requested edits for the minutes? Commissioner Schmidt.

>> VICKI SCHMIDT: My name is just spelled wrong, thank you.

>> CHAIR PROFFITT: We should fix that.

Any other edits to the minutes? Hearing none, I would entertain a motion to approve as amended. We have a motion by Commissioner Hensley. Second in by Commissioner Schmidt.

[ chorus of ayes ]

Minutes are approved as amended.

All righty, commission, we have a couple of contracts to review. The results of the RFP and to make a recommendation on which way to move forward. The first one is going to be in tab 2 of your books for the Cobra administration. I believe director Flory will walk us through the RFP's we received and give us some information here. Director Flory.

>> JENNIFER FLORY: Go ahead, Pete and move forward.

One more.

Okay. The consolidated omnibus budget reconciliation act, better known as Cobra, is a requirement for employers to offer to workers that lose coverage Cobra allows members to continue their group health insurance product by paying the premiums directly. Depending on the reason for the loss of coverage. That may be for 18 or 36 months.

So for our Cobra program for the State Employee Health Plan, we do outsource this, the administration of this is done by an outside vendor responsible for sending out those notices, as well as collecting the premiums. They work on the open enrollment. So we ‑‑ this year that contract is out for bid, and on the next slide you'll see that we did receive two bids. Our current vendor is iTEDIUM, located in the Kansas City area. And they over our Cobra administration today. Total administrative services corp better known as TASC, our prior incumbent in this space. Both of these providers have provided the COBRA administration services on behalf of state. We took both of those into the finalist round.

On the next side we looked at the bids, we determined were the vendors able to provide the services being requested. Had they ‑‑ do they have experience provided COBRA to a similar size group. They do. We looked at the services provided to the members as well as to the State Employee Health Plan state. The reporting, the cost of the services. On the next slide, some of the services that are included in this bid is of course issuing out those all important COBRA notices and member communications and manage the premium payments, reporting, they offer a member portal where members can go in and they can elect to pay their premiums direct through payroll ‑‑ not payroll deduction but through bank draft, have an employee for the employee portal to go in and manage the coverage. They remit the premiums back to the State Employee Health Plan. On the next slide, again, we go over ‑‑ it's kind of what I just went over. Some of what that means, initial notices are the rights that a member has as someone who is leaving the state or losing coverage under the state, what the rights are outlined in the notices. They send the termination notices when the period of time they are eligible for has elapsed or if they fail to make their premiums. They participate in the open enrollment process providing access and information to our COBRA members on the open enrollment.

On the next slide, we have the first of yearly costs comparisons. So in this space, we find that sometimes vendors prefer to bid based on the number of activities they do, versus based on overall population number.

So in this particular breakdown, this is the comparison of iTEDIUMs price and TASC price if they were to bill us on a set number of services. The number is listed in the second column based upon the numbers for plan year 2023.

Compared to the rates that they have proposed to come up with the annual cost and then the three‑year cost.

On the next slide, we have the same two vendors compared, but this time it's based upon just a number of individuals that we have covered under the plan and a flat fee per individual. In this comparison then you have iTEDIUM again and TASC and based on current enrollment. The math is  ‑‑ the number of individuals that have to get open enrollment packets, we use the number from plan year 2023 to come up with that. To show the cost comparison.

With that, I will stand for questions.

>> CHAIR PROFFITT: Very good. Thank you for the review. Commissioners, any questions, Commissioner Schmidt.

>> VICKI SCHMIDT: Vicki Schmidt. So what is the ‑‑ we have a choice then of how we contract with them on the number of ‑‑ based on the number of employees or based on the administrative fee build based on our count.

>> JENNIFER FLORY: Yes. They bid both ways and state can select which one they choose to have.

>> VICKI SCHMIDT: What did we select on the previous three years, which way did we go the previous three years.

>> JENNIFER FLORY: It was per member.

>> VICKI SCHMIDT: Which is the second one. The second one. Can you tell us on the three‑year history of the number on the per COBRA participant.

>> JENNIFER FLORY: I don't have that information, no. Generally our COBRA participation has been in the 250 to 300 range with the changes made last August, that number is likely to go down because more individuals who are retiring will move directly from active to direct bill as opposed to stopping in COBRA.

We had about 120 folks last year at the end of the year that were on COBRA that moved to direct bill. So we anticipate the number will be lower in future years than it has been in the past because of that change. But I don't know the exact three‑year history of how many exact members we had. It's a point in time, it changes as people come and go.

Individuals may elect COBRA are for one or two months because they are in between jobs. Other members may play the system and say oh, well you have a 60 days to decide, I'm going to wait and see if I get a job before I actually take the COBRA. The numbers do fluctuate between year to year.

>> VICKI SCHMIDT: Well, I think with ‑‑ with the changes that were made that allow the early retirees to not go to COBRA and to do the direct bill, I think it would make more sense to do it based on the per COBRA participant, but that's just my opinion.

>> JENNIFER FLORY: The commission has the option to choose that if you so direct us what to do.

>> CHAIR PROFFITT: Thank you. Any other questions? Hearing some background noise online. I don't know if that's Commissioner Dechant.

>> STEVE DECHANT: Yes, it is. You can hear me, I take it.

>> CHAIR PROFFITT: Yes, sir.

>> STEVE DECHANT: Okay, good.

>> CHAIR PROFFITT: Any other questions on the comparison of the plans? Hearing none, I think we are at the point where we would entertain a motion. Commissioner Schmidt.

>> VICKI SCHMIDT: I would make a motion to contract with iTEUM for three years, and to use the ‑‑ to contract with them on the per COBRA by the per COBRA participant of 650 per month.

>> CHAIR PROFFITT: Council, do we have what we need in to of making sure that's clear in the minutes.

>> VICKI SCHMIDT: That would be the one the only cost is projected to be $87,250, correct.

>> VICKI SCHMIDT: Yes.

>> CHAIR PROFFITT: Okay, you've heard the motion, is there a second.

>> ANTHONY HENSLEY: I second it.

>> CHAIR PROFFITT: Any discussion? Hearing none, we'll do roll call vote.

>> VICKI SCHMIDT: Aye.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: Motion carries.

Moving right along to action item No. 3, we have another contract to review, RFP to review. I think this one will be more lengthy. On the health reimbursement and health savings account administration contracts. Director Flory, I believe you'll walk us through this again.

>> JENNIFER FLORY: This contract would be for administrative services for our health reimbursement accounts and our health savings accounts. Health reimbursement accounts are tax approved employer funded accounts that individuals can use to reimburse out of pocket expenses for medical, dental, pharmacy, et cetera, type claims.

The other account is a health savings account, in order to be eligible to put for an employee to deposit funds into a health savings account, they have to be enrolled in a qualified high deductible health plan. That health plan must meet all of the I.R.S. requirements to earn that designation of qualified high deductible health plan. When they do, then the members who elect that, as long as they are not Medicare eligible and there are a few other disqualifiers, for the most part the majority of our employ blows have selected a health savings account, which is a tax advantaged bank account that they own, they can contribute to it, and the employer can contribute funds into that account. The HRA differs in that it is only employer money that goes into that account. Employees may not direct funds into the HRA. At the end of the allowed period, those funds do roll back to the state. So on the next slide, we took this out for bid. We do have a three‑year contract so our contract will be up at the end of the year.

We received five bids, of those five bids we took four of them into the final rounds of negotiations.

On the next slide we look at some of the factors we were thinking about as we reviewed the bids, what services were provided to the State Employee Health Plan and to our members and looking at the cost of the accounts and the fees that would be assessed. Un‑a health reimbursement account, the fees are paid by the state. On HSA, those are employee owned accounts, any fees would go to the members.

We were looking at those and the options that were offered, what type of options did they have as far as investments for those HSA's, what the criteria was for investing, what were the thresholds. There's a variety of things we looked at going into that.

So on the next slide, some of the services that we were looking at was what type of reporting would the vendor be able to provide because there is an interface with payroll on those HSA dollars, it's important we be able to get accurate information they handle our reports in a timely fashion to ensure that member's money flows to their checks in a timely manner.

We were looking at the member portal, how easy it was to and a half fate, what services were available, what could a member do on the portal. What could the State Employee Health Plan, what were available to us on the staff portal to review information, access reporting and that type of thing.

We also looked at what type of communications and educational materials the vendors were providing to our members.

So on the next slide, we jump into pricing. We start with HSA pricing. The HSA, again, this is all employee money, as far as fees. Any fee would be paid by the employee, not by the state.

We had the four bidders that we took into the finalist round were Central Bank located in Missouri. They partner with ASI Flex, so that is a prior flexible spending account provider that the state has done business with. They partnered as ASI Flex in to go the flexible spending account. We do have experience with them, and their ability to offer services and to provide them to our members.

MetLife is our current incumbent. They've been providing the HSA and HRA services for the last three years.

NueSynergy is the prior incumbent that has offered to the state prior. We did have Optum, it's been a number of years ago, but we originally had a contract with ‑‑ what was the bank? U.S. bank and U.S. bank sold that contract to Optum and so for a period of time we did have Optum as a vendor. We know how four of these vendors have the capacity to provide the services being requested in the RFP and to do the health savings accounts. With central bank, MetLife and Optum, there is no monthly fees on the accounts. However, when we get to a later slide, we will disclose there are some fees under the Optum contract for other services that a member might encounter on an HSA.

With NueSynergy, there is a 45‑cent account fee the employee would pay. We show the projected cost.

On the next slide, we'll go over the HRA. This is the employer side of the account. These would flow to the state. We had far fewer HRA's. With that, we have currently account 1,674, and you'll see that Central Bank, MetLife and Optum are quoting no fees to the state for providing that HRA service. NueSynergy is quoting $1.45. The annual cost of the fee and the three‑year cost of that fee.

So in the next slide we go over additional information. MetLife is our incumbent, they have been administering our HRA/HSA for the last three years. MetLife and Central Bank include no member costs for the HRA, and there are no charges for other services they might offer, like paper statements, use of an ATM. Et cetera.

NueSynergy has other fees for return checks, paper statements and account closure fees. Optum, while they have no monthly fees for the HSA or HRA account, they do have fees for some other services which include an account closure fee, an ATM fee and paper statement fee.

With that, I would be happy to answer any questions.

>> CHAIR PROFFITT: Thank you for the review. I do have a question. With MetLife as our current incumbent, they have no monthly fees, as you stated back on slide 23 in my book. Slides 23 and 24. Do they currently have account closure fees or transfer fees or anything. So if they were not to be the successful bidder, are there fees associated with that.

>> JENNIFER FLORY: No, there are not.

>> CHAIR PROFFITT: Commissioners, any other questions?

Commissioner Schmidt.

>> VICKI SCHMIDT: I do think there is ‑‑ after talking with some of my employees that do have HRAs, and ‑‑ I'm sorry, HSA's, the HRA's would affect the state. But that have HSA's, I think that with the Met life and Central Bank offering zero on the monthly fee per account and certainly the additional fees, I think that the preference of the people that I have spoken with, would be to stay with the current vendor just for ease of the accounting process and would be just no change for them.

So I would make a motion to continue the three‑year HRA and HSA administrative contract with MetLife.

>> CHAIR PROFFITT: Commissioners, you've heard the motion, is there a second.

>> STEVE DECHANT: This is Steve Dechant, I second approaches second by Commissioner Dechant. The motion is to extend the contract with MetLife for three years who the current vendor. Any discussion?

Hearing none, we'll do roll call vote again.

>> VICKI SCHMIDT: Aye.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: I'm again showing four affirmative and getting a thumbs up from counsel, motion carries. Thank you very much.

Commission that concludes the action item portion, we will move on the equally important reports section. So we'll move into tab 4, which is a more in depth review of the open enrollment report. This report was e‑mail the around to the Commission, I believe. We did get it to the legislature by the deadline, which is the day that the Governor's budget is released. Just going to do a more in depth review and director Flory will walk us through this. If we have any questions, we can have her answer those. Director Flory.

>> JENNIFER FLORY: We'll go through the open enrollment summary that will provide the commission with information about where employees landed during the most recent open enrollment that occurred in October. So if we move forward, Pete, we'll start with the active employees. So you can see that 34,261 or 87 percent of state employees elected to enroll in a health plan. We did have 5,126 who elected to waive their coverage.

On our nonstate public employers, we had 3,524 enroll with 332 of our nonstate public employees deciding to waive coverage.

Plan A had the highest enrollment with 18,558. Followed very closely by Plan C, with 15,788. Plan J, again, as a reminder to the Commissioners, it is designed specifically to address the needs of anyone in this country on a j1 Visa. It is available to any employee who wishes to enroll, because of that particular plan design, it tends to not be as popular because it tends to have a little bit higher cost to meet the deductible requirements.

Plan N is the other high deductible health plan available to employees, this is our low cost plan, and we had 2,799 of our employees elect to take that.

On the next slide, we break it down between Blue Cross and Aetna so you can see that Aetna has 3,554 of those contracts, Blue Cross has 34,231. Those are the TPA's that provide the services on behalf of stay to administer the programs.

On the next slide you always like to know how many switch. And you can see the number is pretty consistent 295 went from Aetna to Blue Cross and 303 went from Blue Cross Aetna.

On the next slide, we break it down further with regard to our different plans. We show you Plan A, c, j and n, how heaven of those individuals elected the Blue Cross option versus the Aetna option.

So, again, on the next slide.

>> CHAIR PROFFITT: I'm sorry to interrupt. Hit the pause button. These are the 37,785, that is number of contracts. Number of covered lives is greater than that.

>> JENNIFER FLORY: Yes, these are contracts. We'll get into on the next slide, we'll start looking at more information about the coverage.

So these, again, are contracts, these overwhelmingly, as has always been the case as long as I worked for this health plan, employee only coverage dominate with 20,818. Individual selecting to have single only coverage. Employee children is the next most popular option with family and followed by at the bottom employee spouse condition coverage with 4,207 contracts.

On the next slide, we break down the dependents even further so you can see. Total state dependents is 31,383. Of that 31,355 are spouses and 23,028 are children. We provide the same breakdown for the nonstate public employers, 2385 children, 874 spouses. At the bottom we show you the total we have 9,229 spouses and 25,413 children covered. So those are lives that add to the contracts.

On the next slide we go through some of our optional plans and, Pete, this isn't the most current version. We had a problem when we converted our slides from a PowerPoint over to the packet and the headers dropped off. Dental we have 38,402 individuals that elected to enroll in a dental plan. Commission will remember a few years ago, we split dental from medical so dental only if that's all you wish to purchase. It should have a header right above where it says basic plan that says prescription eyewear insurance coverage. There are 32,113 individuals who have elected to enroll in one of the voluntary prescription eyewear coverage plans. The enhanced plan was the most popular, 23,177 contracts. The basic plan has 8,936.

We will send out a corrected deck to the Commissioners because this one is missing headers. On the voluntary insurance side, these are all employee paid dollars on the voluntary insurance, as is the eyewear coverage. Accidental injury was the most popular option, we did go with our new vendor this year, remember all employees had to go out and actively elect voluntary insurance if eat that they wanted to be enrolled since we moved from Hart toward to fit life. 15,146 of those elected to do that and take accidental injury coverage. Below you'll see the critical illness, there are two options available. And we had over 10,000 employees elect one of the critical illness policies.

Then on hospital indemnity we had 11,134 that made an election. Again, there are two options, 10,000 option or $20,000 option, and employees selected between those as may made their election. Those, again, are all employee paid dollars.

On the next slide, again, we are missing a header. Over there on the right, it should say health accounts, there are 18,604 health accounts, these are the account based enrollments. Of those 16,908 are health savings accounts. 1,696 are health reimbursement accounts. Again, that is the least selected option, but, again, it is a necessary option for individuals who are Medicare eligible, have tri care coverage, they are only eligible to take the HRA because those are qualifiers for enrolling in an HSA. Flexible spending account, this is an option. The medical can be used by members on Plan A, Plan J or if you are on Plan C or n and have an HRA, you could enroll in a medical flexible spending account. This allows you to set aside pretax dollars to pay for your unreimbursed medical prescription drug or dental expenses. The limited purpose of FSA is for Virginia on HSA because they have an HSA they are not allowed to set aside pretax funds for additional medical expenses. But they can set aside additional pretax dollars to use for vision or dental expenses.

The dependent care account, that flexible spending account is for child care or adult daycare expenses, we have 1,585 individuals who have elected to enroll in a dependent care flexible spending account.

Commuter benefit was new last year. This is an option, there are two options within this, you can take a parking benefit, parking would allow you to set aside funds pretax to pay for parking outside of a state‑run facility because the state in some campuses do charge for parking. But they already have a pretax versioning of that, like at the University of Kansas, and the University of Kansas medical center, this would be for individuals like myself who I park in a city‑owned parking lot and pay that fee out of my pocket. I can set aside funds to pay for my parking using this account. Mass transit allows individuals to set aside funds to pay for public transportation, such as a bus or the state Van pool. We have 69 individuals who have elected to do that.

On the next slide, individuals who failed during this open enrollment to make an election, the health care commission had set up an option for an individual was enrolled in medical insurance during plan year 2023 and during the 31 days of open enrollment they did not go out and make an election, they were defaulted to Plan N with an HRA.

The reasoning being that Plan N is our least expensive program so we are not committing more of our employee dollars than necessary and the health reimbursement account, again, because those are all employer dollars and we are obligating our employees to additional expenses.

This year, we have 450 individuals who fell into that category. Of those individuals, 408 of them were state employees, and 42 of them were our nonstate public employees.

147 of that 450 were already enrolled in Plan N during calendar year of 2023 anyway. Those individuals did get moved to Plan N for next year. If they were enrolled in Blue Cross in 23, we moved them to Blue Cross with Plan N in 24. If they had Aetna, they stayed with Aetna. We keep them at the same coverage tier with the same vendor, moved them to Plan N so we ensure they have coverage for the following year.

>> STEVE DECHANT: Jennifer, was there any pushback or comment or ‑‑ from any of those 450 people.

>> JENNIFER FLORY: I'm only aware of us being contacted by one individual, and we were able to ‑‑ we could not move them out of Plan N because the plan year had already started. We did move them to an HSA so they could set aside some funds pretax to help pay for the deductible. There is ‑‑ the person was on a plan that was more expensive, so they were able to set aside those funds, the reduction in premium into an HSA to use for their health care expenses.

>> STEVE DECHANT: Okay. Just one. Okay. Thank you.

>> JENNIFER FLORY: That's the only one I'm aware of. There could have been others, to my knowledge that was the only one I was aware of.

>> CHAIR PROFFITT: Commissioner Schmidt you had a question.

>> VICKI SCHMIDT: Thank you. I know you said if they were in Aetna or Blue Cross, you kept them in that. If they were not, how did you decide.

>> JENNIFER FLORY: You have to have had coverage in plan year 23. You had to have enrolled and been covered under Plan A, c, j or their to be defaulted. If you waived coverage in plan year 23, your waiver would remain in place until you actively go in and enroll.

So if you didn't have medical coverage, we did not enroll you in medical coverage. We ensured if you did, that you didn't lose.

>> VICKI SCHMIDT: So if an individual waives coverage in 2022, it remains waived without any action, and ‑‑ so we don't really ‑‑ okay.

>> JENNIFER FLORY: They stay waived until they go in and take an action to say, I want coverage.

>> VICKI SCHMIDT: So they don't have to do it every year.

>> JENNIFER FLORY: No, it rolls from year to year. Approaches any other questions while we are paused? Okay. Go ahead.

>> JENNIFER FLORY: We'll move on to our defect bill open enrollment. So direct bill open enrollment was ‑‑ it's offset from the active, it starts on October 16 and it runs through November 15. We do bring in a call center, they are individuals who are former state employees, many of them from the ‑‑ had HR backgrounds to come in and answer the phones so our individuals who are out there and not able to ‑‑ they can't enroll themselves in map, they can call and we will help them get enrolled with the call center. It's an option for the direct bill members.

This group of direct bill members, these are the ones enrolled under the Non Medicare programs, which we refer to as the active n plan. 106 are in Plan A, 175 on Plan C, 3 on Plan J and 5 on Plan N.

Let's move to the next slide. So this one, we are looking at our direct bill members who have Medicare coverage. The header missing on the right hand side. The header on that should read Medicare Supplement insurance, and we have 7,093 individuals who are covered under one of the state's Medicare Supplement plans. Kansas senior Plan C and senior Plan C select, these are plan options that due to changes in the requirements that the Federal Government has, they are no longer open blocks, individuals cannot ‑‑ newly eligible Medicare people cannot enroll in Plan C or Plan C select. But individuals who are already enrolled in those they keep them for as long as they like.

The difference being that the newer plans, like plan g and n, do not cover the Part B deductible and Plan C does. There is a requirement now under CMS we cannot over that to newly eligible Medicare members.

The select option you see, the difference between senior Plan C and senior Plan C select is in certain select markets. If you enroll in that program, you are limited to a specific hospital in a nonemergency situation. So that's the difference between Plan C and Plan C select.

So for our individuals enrolling today, they can choose Kansas senior plan g, senior plan g select or senior Plan N. Individuals in this market do not have to make an active select each year, their coverage will roll from year to year, unless they choose to make a different election, we do not require them to enroll.

We also offer Medicare Advantage programs, we have offered these for a number of years. While the enrollment number isn't super large, it has grown over the years and we are now up to 831 contracts. This is available through Aetna, it's the advantage freedom PPO and advantage elite PPO, these programs include both the medical coverage as well as the Medicare Part D coverage. Automatically included for those individuals.

On the Medicare Supplement side, those individuals do not automatically have prescription drug coverage with us. So on the ‑‑ go ahead.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman. I wanted to make sure that I understand this correctly. If you were to elect to go from a C to an N, you have to go through underwriting if it's not the first.

>> JENNIFER FLORY: Not with us, you do not. During open enrollment if a person wanted to move from plan g to Plan N, they would be allowed to do so.

>> VICKI SCHMIDT: In the open market they have to go through underwriting.

>> JENNIFER FLORY: There are some advantages, it is not age rated, another difference between us and the open market. As you age your premium does not go up because you age, but for our individuals who are just becoming Medicare eligible, our rate may be higher and the break‑even point I believe is it 71? It's 71. At age 71 our plan starts to become cheaper than the open market because we are not age rated.

>> VICKI SCHMIDT: So six years. Thank you.

>> CHAIR PROFFITT: Any other questions while we are paused? Okay, go ahead.

>> JENNIFER FLORY: On the next slide, we are looking at the dental enrollment, again individuals who are in the direct bill program, if they want dental, they have to enroll in that when they retire, they are allowed to continue that optional dental coverage as long as they like. They can elect to only pick dental if they don't want to take our medical insurance and buy it in the open market. They're free to do so and just take dental with us. We have 8,241 enrolled in the dental. Over on the right hand said the header should read prescription eyewear insurance, we have 5,549 of our direct bill participants who have elected to enroll in one of the voluntary eyewear prescription coverage plans. With this population, again, the enhanced plan is more popular with 4,547 enrolled in it. Versus just about 1,000 in the basic plan.

The big difference is kind of obvious why they would pick the enhanced plan because the enhanced plan covers your no line bifocals and has a higher benefit there are that. It's going to be more popular with an older population.

Okay. On the next slide, we should have our direct ‑‑ this is our Medicare prescription drug coverage. Prescription Medicare Part D enrollment. It should read SilverScript Part D. 1953 that have elected to enroll. This is an optional program, so if I take a Medicare Supplement policy through the state and I wish to enroll in Part D coverage available in the open market, you are allowed to do that. You do not have to take the state's prescription drug coverage if they don't wish to.

With our plans we offer two ‑‑ our premiere plan has always been a little more enhanced version than what's available in the open market, and you can see that clearly it's more popular with 1,543 members selecting the premiere. The economy plan we brought in a couple of years ago, it's more in line with what's available in the private market. It's a lot less expensive. It has gained popularity over the last couple of years with now up to 410 contracts.

And with that, I will be able to answer questions. In the back in the appendix, we have provided for your reference, we have given you like five years so you can see what did Plan C's enrollment look over the last five years and break out between Aetna and Blue Cross. We have the number of waves. All of that detailed information is in the back.

>> CHAIR PROFFITT: Very good, thank you very much, Jennifer, appreciate the review there. And yes, Commissioners, there's a whole host of detail on the back. I thumbed through quite a bit of it. There's good information. One thing that stuck out to me slide 26 or 51, employees who did not actively make an election, 2023‑2024, you can see that the numbers are substantially lower this year than last year, there's been a downward a trend from 2023‑24. Feels like we're making the outreach to employees and getting a better uptake rate, which is good news as a Commission, that's our role.

Any questions or comments before we move off of this report. There was a lot to take in there.

I will ‑‑ Commissioner Schmidt.

>> VICKI SCHMIDT: I would say if you send us the slides with the headers, could you just send us the slides we this headers and not the whole packet again.

>> JENNIFER FLORY: Your secretary already has the whole deck. I sent it to her yesterday. Because I knew you printed your own. She was going to replace it in your book.

>> VICKI SCHMIDT: Some of those replaced but not all of them.

>> CHAIR PROFFITT: Let's parse out section 4 and resend it to the Commissioner, please. Any other questions?

I'll mark this as a comeback item if anybody has anything that pops into their head.

Seeing nothing further at the moment. Thank you, director Flory for your reports and ‑‑ your reports and counsel. We are going to move on to item No. 5, which is the benchmark study we have asked our friends from Segal to do. If you can come to the mic, introduce yourselves and Commissioners we are on tab 5.

>> PATRICK KLEIN: Patrick Klein with Segal. God morning. So the purpose of the benchmark study is to compare the Kansas plan with other state health plans. The focus ‑‑ we are really focused on the plan design and the cost components of the plans and their comparisons. We actually did the same study more or less the same study four years ago. So it's interesting to see how the results have changed. And a lot of that has to do with the decisions made over the last four years. You'll see some improvements on how the Kansas plan stacks is up against some of the competition.

And we have a larger deck that's most of the slides in the appendix. That's a little too detailed for today, so we will focus on executive summary. But if there's any questions on other slides, I'm happy to walk through those.

Given that over 90 percent of the enrollments in Plan A and c, those are the two plans we were focused on. Plan A, we have comparisons against PPO's nationally and regionally, Plan C looking at high deductible plans, consumer health plans. The regional states we chose, these are the same as the last presentation. We have five neighboring states and we are looking at medical and pharmacy and, again, the key pieces we are looking at are the plan design, all the various components, deductibles, copays, out of pocket maxes, any cost sharing on the different plan designs for medical and pharmacy, and then what they pay for the design, low pays for it, what's the employee contribution, employer contribution.

The Kansas and regional state information is as current as possible and the national data comes from our 2023 Segal state employee benefit study. There are some ‑‑ there's some information where we need to leverage the 2018 study and trend that forward.

So here's kind of a map of the plans we are comparing against, your neighboring states and their various plan designs.

I won't go into too much detail here, but it looks like Missouri and Nebraska have similar structures as Kansas. So you have a PPO and high deductible option. Oklahoma and Colorado, they have more plans and offer a decent amount of HMO's alongside those.

And these abbreviations you'll see these on the next couple of slides. This is kind of a key for the graphs we'll show later on.

Skip over the key findings. I don't want to spoil all the good information here.

So the ‑‑ this slide here is talking about what offering in terms of the type of plan you guys versus your comparison.

Everybody offers a PPO for the five neighboring states, offer a high deductible plan and three offer HMO's. I think just working with different states and knowing about the national survey that it's ‑‑ I think it's more rare to have an HMO, it's pretty common to have the PPO in a high deductible option.

So the next series of slides, we are ‑‑ they'll be structured kind of the same way where we have all these various regional plans that we are comparing against. The Kansas plans are in the light blue teal and then the regional plans are in a darker shade of blue.

This first comparison is the actual real value. Are ‑‑ actuarial value. That's measuring the percent that the plan picks up claims‑wise through the plan. And so the complement of that, if it's an 80/20 plan, the plan would pick up 80 percent of the claims, the member pick up the remaining 20 percent through deductible, coinsurance copays.

Higher the actual ‑‑ the actuarial value, the more benefit to the member. We pulled in the actuarial value from 2020 so you can see how things have changed over time. I know there's been a big focus on Plan A lowering the deductible, lowering copays over the last four years. You can see that plan's actuarial value goes from 80 percent up to 85. Before it was on the lower end of the spectrum here and now it falls pretty right in the middle. Plan C, there hasn't been as many changes done there, but that's one of the most valuable plans we are comparing against. A lot of that has to do with the HSA funding.

Any questions on the actuarial values.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Will you go back to page 83 or 84, the key findings that slide, will you go back to that.

>> PATRICK KLEIN: Yeah, I'll wrap up with that.

>> CHAIR PROFFITT: Go ahead.

>> PATRICK KLEIN: Now we are talking about total premiums. In theory this should be the total revenue needed to cover the plan's cost, and the way that's broken up, the total rate and then what the employee pays in and what the employer pays. So we have a stacked bar here where you can see the full bar is the total premium and then on the bottom, it's a little hard to see, but you can see what the employee piece is and then the darker color is what the employer picks up.

So over here for Plan A and Plan C, your total rights or total costs are a little bit higher than the benchmark plans. Look at the contributions, these small little bars, kind of bounces all over the place. So your Plan C, you're paying the members are paying a little bit less for single coverage than Plan A. The employer piece, the bar is the exact same length. The same dollar amount for the employer side.

But some plans, they're not charging any contribution, we have other plans here that charge higher contributions. So it's kind of all over the place, but the takeaway here is that your rates are a little bit higher and part of that is you have higher value plans, we just saw the, Plan C is a higher value plan. This has to do with the underlying risk of your membership.

The allowed cost, this is for single coverage again, it takes the premium rates we saw before and then it adds in what the member pays out of pocket for their claims. So those are claims that never get seen by the plan since they're paid by the member.

So this is a function of how rich the plan design is. So a lower AV plan or actuarial value plan, you should see more out of pocket claims.

Why I like this slide, it normalizes for plan design. Essentially all of these are on 100 percent actuarial value. You can really get the risk or the underlying costs of plan after you normalize for the plan design itself. And no surprise, Plan A is higher than Plan C, I think it's common that the risk to the population, they like the idea of copays and they're not going to be selecting a high deductible plan necessarily.

This plan at the bottom here is a Nebraska high deductible plan, I worked on the state of Nebraska and I know for a fact only 15 percent take that plan. There's no HSA. The only reason people take it because it's the lowest contribution. So it's really for those young invincible folks who think they only use the system at all. So even ‑‑ the cost is lower, it's a function if you look at the average age of that plan versus Plan A, you'll see a ten‑year difference.

I would say this is the most powerful slide in the deck because we are combining what the employee pays for the coverage, so through their contribution and what they pay out of pocket for claims.

So it's really combining ‑‑ you can have a plan design where you have only a $100 deductible, $10 copay but if you're charging $1,000 a month for that plan, is it really valuable to them. This combines the plan value and what they pay through the contribution.

In one way, you King it's a percentage. So in one way, it's what percentage of the total overall cost in the entire system is the employee paying through contributions and through claims. The complement to that is what we are showing here, which is everything they are not paying the plan is pick. The total employer state subsidy is what we are showing here.

So Plan C is looking ‑‑ really Plan A and Plan C are both somewhat in the middle of the pack, Plan C is ‑‑ does have more richness and that's a function of a lower contribution and a higher value plan design.

But it is nice to see that when I bring in the 2022 ‑‑ the 2023 ‑‑ 2020 exhibits, there has been improvement in both Plan A and Plan C.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman, that's on the single plan.

>> PATRICK KLEIN:

>> VICKI SCHMIDT: The next one we go to the family.

>> PATRICK KLEIN: The family is a different story.

>> VICKI SCHMIDT: Why didn't we do it for the employee response and employee children, didn't we do that also. I think employee spouse would show a totally different picture.

>> PATRICK KLEIN: That's a good point. Yeah, we only had so many slides, and that's just kind of the direction we have went. Look at employee and family. The way you have a flat employer subsidy for employee spouse and employee family, it's the same amount. A lot of plans, it's staggered, you wouldn't see ‑‑ if you looked at employee plus spouse and family, the story would be the same. But yours is going to be a little bit different. I'm happy to rerun those numbers and bring in like a employee spouse comparison. I think it was ‑‑ it's what we typically do.

>> VICKI SCHMIDT: I'm not asking for the whole slide deck to be that way, but I think on this richness plan, as we go into talking about plan design for the next year, I think it would be interesting to see that employee spouse and employee children. The other question I had was on the HSA side of the ‑‑ on the Plan C side of it, does ‑‑ there's a potential of the 50 points of the more employer contribution to that. Are the 50 points, is that included in this.

>> PATRICK KLEIN: No, none of the wellness ‑‑ what can be earned is included in the comparison. It's tough with all the benchmark plans because they have their own smoker surcharges and different credits that people can earn. We just don't know what percentage ‑‑ we try to keep everything on a base level. In the appendix ‑‑ sorry, flipping around here. We did bring in what the contribution is so you can kind of see that $40 credit on the contribution side. But as far as these comparisons, we didn't know what the regional states were doing, try to keep it apples o apples.

>> VICKI SCHMIDT: In some ways if a Plan C participant were to take advantage of all the 50 credits, that would increase the richness of that plan even more.

>> PATRICK KLEIN: Absolutely.

>> VICKI SCHMIDT: Certainly the richness compared to Plan A.

>> PATRICK KLEIN: Absolutely, yeah.

>> CHAIR PROFFITT: May I piggyback over that. Is it fair to say this is sort of the almost worst case scenario or most basic level of the richness of the others, it only improves.

>> PATRICK KLEIN: Your plans, your richness would go up for anybody getting the wellness credit or HSA seed money, but then your neighboring states, they have their own wellness initiatives and smoker surcharges, so theirs could go up.

>> CHAIR PROFFITT: In a stand alone simply looking at the state's richness percentage, we could articulate this is the baseline and only gets richer when you add the wellness. Forget the peer states.

>> VICKI SCHMIDT: Thank you for that clarification.

>> PATRICK KLEIN: We'll switch over to family coverage. It's a little bit of a different story here. If we focus on the premiums, you can see that when we are looking at ‑‑ again, it's made up of the employee piece and employer piece. The employee piece for Plan A especially, you know, is an outlier, right, compared to the other plans and what the contribution is. So Plan C is higher than most other plans. Again, that's kind of a strategy that was in place. So it's ‑‑ I guess it's kind of a whatever policy you want to have. At the time I think ‑‑ probably speaking out of turn here, but it depends on where you want to put your money.

Some people, they don't want to subsidize dependents, they think they could get their coverage on their own health plan or whatever the case may be.

So anyway, I'll stop there. Why I think that's why the contributions are so much higher there in Plan A and Plan C. That contribution amount is really what kind of drives the next couple of slides.

So we get to the allowed cost on Plan C and Plan A are a little bit lower, Plan A is right in the middle. Again, this is more a function of the risk that's in the plan. I'll flip over to the richness. There has been improvements in Plan A and Plan C, so Plan A was way at the bottom, but, you know, it's getting closer to the rest of the benchmark plans, and Plan C has also seen improvement. Again, it's on the lower end of the spectrum there.

Any questions.

>> CHAIR PROFFITT: I don't think you can probably answer this question, but I'll ask anyway. So as I look at the richness, it looks as though specifically for the family, both a and c are decidedly on the low end of the spectrum. If going to back to the annual report Jennifer was covering earlier, the enrollment by tier, obviously employee only being the highest and employee plus family among the lowest, I think that is likely a direct correlation between the two. Something to keep in mind as we move forward. Not suggesting we take action one way or another, but something to look at.

Any other questions, Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman. This isn't directly related to the slide you presented, but I would like to bring up a topic that I think we have had previous conversations about, as long as we are talking about the plan richness and the plan things. This is in regard to the valley hope and residential treatment facility exclusion issues that I've brought up before.

I know that I've had some meetings and I wanted to report back, again, just in the richness of the plan and what we cover and what we don't cover.

So the insurance ‑‑ and may or may not ‑‑ I'll back up a little bit. May or may not remember, Valley Hope has several ‑‑ has a couple of facilities, I don't know how many exactly, Norton is one of them. They have some facilities here in Kansas for substance use disorder, and the State Employee Health Plan does not pay for room and board with ‑‑ when an insured from the State Employee Health Plan goes into Valley Hope, we don't play for room and board.

So we ‑‑ the insurance department surveyed, we were ‑‑ we thought it would be a good idea to give you a comparison and survey some survey some things. So I wanted to report to you, I'm not asking for an action item today, but what I am asking is that for more research be done and that at the next meeting maybe be able to put this on the topics to discuss or to get more ‑‑ if you want more information that we haven't looked at yet. We would entertain that.

The insurance department staff surveyed our TPA's, and our ‑‑ our third party administrators, Blue Cross Blue Shield of Kansas and Aetna regarding the coverage of the room and board under large group policies. Each carrier indicated that they provide coverage for room and board in a residential treatment facility. So we would clearly be the outlier here. We also looked at, surveyed our surrounding states, amazingly, the same five states that you surveyed, we surveyed for that, again, the coverage was largely provided for in the residential, for the residential treatment centers.

So instead of looking at the benchmark in ‑‑ I can appreciate why you look at it this way, instead of looking at it purely in the financial terms, it might have been helpful to look for you to look at the benefits and the exclusion as well and what those translate to in the overall spending of the individuals.

But I know that ‑‑ I know that the CMS came in and did a market conduct examination of the State Employee Health Plan. I think it was concluded in 21‑22. And it appears that the remedy ‑‑ there was a failure to achieve parity with the facility type in that market. Conduct examination.

But a decision was made effective January 2020 to exclude skilled nursing and residential treatment for the mental health, sud conditions. What that means is that if you would have ‑‑ this is what I think this means. Correct me if I'm wrong, if you would have an employee have a stroke and need to go to a rehabilitation center to regain function after a stroke, they would be a state employee on the State Employee Health Plan, what the decision that was made in January of 2020, not by HCC was we won't cover room and board for that. So that we would not be in violation of mental health parity.

So we are so adamant we wouldn't cover it for SUD we took that benefit away from the state employees. I did not know this. I don't recall that decision was brought to the HCC for consideration, I know Mr. Chairman you weren't here during that time.

I am fairly certain I would have remembered that type of discussion because I feel very strongly about it, obviously.

So I would respectfully request that the Commissioners ‑‑ that the HCC be provided information about how that particular decision was made by staff and did the TPA's or the consultant, which would have been Segal at the time, did you provide any guidance or recommendations, I'm very concerned about how this decision was made to update the summary plan description and how was that communicated.

How often are those documents reviewed, and is that jointly with Aetna and Blue Cross Blue Shield of Kansas and do we consult with outside counsel? Ultimately, the decision to include or exclude benefits is significant, and I believe that is our responsibility, and I think it deserves greater transparency and oversight by the HCC.

So I look forward to continuing those discussions. I can certainly ‑‑ I have forwarded these questions to Jennifer already, to Director Flory already, and I would like to be able to have that put on the discussion for the next meeting.

I just ‑‑ again, I have very strong feelings about that and the fact that instead of doing what I think would have been the right thing to cover ‑‑ to remedy the situation of the to cover it, instead of taking away room and board for rehabilitation ‑‑ let me clarify that if you remain in the hospital, we pay for the room and board. The minute you go to a rehab facility, we don't pay for that. I really can't believe we haven't had more complaints about that if that's what we are doing, if that's truly what we are doing.

So that's my hope.

When we get to other items, I have another one for the next meeting.

>> CHAIR PROFFITT: All right.

>> VICKI SCHMIDT: Fair warning. Thank you for indulging me, I do appreciate it. I do think these are important things the HCC should be a part of the process.

>> CHAIR PROFFITT: Very good, thank you very much for your comments. As noted you did send the questions to Director Flory last night, I was cced on that, we'll make sure we have those reflected accurately in the minutes. I'm picking on words here and may be overly sensitive. I think there was a comment why did ‑‑ figure out why the staff made the decision they did. I want to determine if the staff by themselves made that determination or if there was consultation with anybody else, want to clarify that statement for the record.

>> VICKI SCHMIDT: I did go on and say did they consult with consultants, outside consultants, but I know HCC was not consulted.

>> CHAIR PROFFITT: Fair enough. I want to make sure we are clear.

>> VICKI SCHMIDT: I did go on and say the other part of that. But definitely, that's what ‑‑ that is what I'm looking for.

>> CHAIR PROFFITT: I think we understand the spirit of the request and certainly take the request seriously. We will dig into that and get all the historical information and reference documents for the Commission and have that included in the next Mike, as appendix material at your request, I can add discussion. I want to make sure the discussion item will read residential treatment facilities and not one specific provider, although ‑‑ so I think you're on board with that. Just want to make sure we're clear. We will add that for a follow up for the next meeting. I believe one other request that came about this was to circle back just for the next meeting with the richness only slide for employee spouse and employee children so you can confirm we can get to that by the next meeting.

>> PATRICK KLEIN: Absolutely.

>> CHAIR PROFFITT: Any other questions, comments on the benchmark study. Commissioner Cain.

>> CRISTI CAIN: Thank you for binging that the attention. I think it's important we examine that. I'm looking forward to that discussion at the next meeting.

>> CHAIR PROFFITT: Very good.

Any other questions or comments on the benchmark study before we move on?

>> PATRICK KLEIN: The other slides in the appendix, going into more detail on the plan design features themselves. Those all get rolled up into an actuarial value. You can see if you want to break apart deductibles versus coinsurance and some of the pharmacy benefits. That's where this is. Yeah, we'll move along then if there's no questions.

>> CHAIR PROFFITT: Actually, Patrick, can we ‑‑ we were at appendix material.

>> PATRICK KLEIN: Yes.

>> CHAIR PROFFITT: Is now the perfect time to circle back.

>> PATRICK KLEIN: Again, comparing against 2020, the plans have improved on several metrics. The plan value we talked about that, that's a function of benefit design enhancements that have been made in Plan A and Plan C. Employee contributions have been held flat over four years, I believe. So while your competitors or the regional states, there's been some increases across that, so all those things are contributing to better overall plan richness, as compared to the last study.

Again, Plan A on the single and family is a richer plan because you have a lower contribution and higher actuarial value.

And then Plan A's actuarial value is close to the average benchmark. The benefit features where the member cost share was a little bit higher included emergency room utilization and figure brand drugs.

Plan C, the reason why their actuarial value is on the high end of the spectrum is because of that HSA contribution, and if you earned more credits, that richness could even be higher.

But then the last bullet is the family coverage is a different story, that's lagging behind and mostly due to the contributions and the way the employer funding works for that plan, for that tier.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I do have a couple of questions ‑‑ I never know which page to tell you, 30 or 109 on the average cost per script retail generic. Yeah. So while I know that the $10 and $9 and $12 on the PPO plan, from 9 to $12, that's still 20 percent difference. So I think that's something that we should look at. Then on the average cost per script on the next slide, the retail formulary brand, we are way out of whack with that one. I think those ought to be ‑‑ which is slide 31 or 110, those are way different from our competitor ‑‑ our neighboring.

>> PATRICK KLEIN: It's a function of, especially on the PPO, typically there's a copay structure for that, and the state health plan has a coinsurance. So that's why there's a difference there.

>> PATRICK KLEIN: Other states don't have that.

>> PATRICK KLEIN: They typically use a copay structure. For high deductibles, everything is kind of running through the deductible and coinsurance. PPO, it's more common to see copays for brand generic.

>> VICKI SCHMIDT: That has been a common thing with our plan, we have at a coinsurance plan design since about the year 2000, which has been a more advanced structure than what other states have had. One of the benefits to that is if the drug is of low cost, the member is only paying 20 percent of the actual cost versus a $10 copay when the drug only costs $3. Why on the flip side, there are some drugs where a member may pay more. Overall the plan design using coinsurance has been a positive because it didn't require us to make changes to the plan as costs of drugs changed. It allowed many members to get drugs for less than what they would have paid for a flat copay.

So it is different, we are a different being a coinsurance plan. Our pharmacy program is very much different than what many of our competitors in other states are. I can tell you some of those states are very envious we have the structure we have with the point of sale rebates and coinsurance design.

So there are positives and negatives of both sides of that.

>> VICKI SCHMIDT: It looks like the big negative for the consumer.

>> JENNIFER FLORY: Not necessarily, if you're taking a generic drug you're only paying 20 percent, it costs $10, you'll pay less than if you had a $10 copay.

>> VICKI SCHMIDT: The previous slide doesn't bear that out. It says we are paying 20 percent more than our surrounding states.

>> JENNIFER FLORY: We are a coinsurance plan design and they might be.

>> VICKI SCHMIDT: It doesn't bear out in the numbers. We are paying 20 percent more on generics than our neighboring ‑‑ than our neighboring states. 9 to 12 is 20 percent more.

>> JENNIFER FLORY: I would suggest that the coinsurance plan design has served the state very well over the last few years and versus a flat copay that is more difficult to adjust and particularly as drug costs are continuing to increase, has been a very positive thing for the state. Reflected in our spend. Paying more, but that also means that our employees have a stake in making the best possible choices because when they pay less, the state pays less. When they pay more, the state pays more. With copays you don't have that. You have a flat copay the member doesn't have an incentive to make the low cost choice.

>> VICKI SCHMIDT: When you say it's better for the state, is it better for the employee.

>> JENNIFER FLORY: Yes, when the plan saves money, the employee saves money, if they pick the low cost product, then they're going to pay a small amount of that low cost product. If we have a flat copay, you know, what's their incentive to pick the low cost generic, what's the incentive to pick the lower cost. There isn't one. If I'm only going to pay $20, I pay $20 regardless of cost. Our plan design was set up so that the employee and the employer share in the cost of that drug so that those decisions, we encourage our employees to make the low cost choice when one is available to them.

>> CHAIR PROFFITT: If I ‑‑ I'll interject here. I think we are jumping into a philosophical discussion on incentives and dynamic pricing models and things of that. How difficult would it be to look back over time, because this is valuable data, but it is a point in time, as I understand it. How difficult would it be to look back over time to compare what our ‑‑ what this would be relative to the ‑‑ over ten‑year time frame, saying it could fluctuate.

>> PATRICK KLEIN: This came from our most recent state employee benefits study. We haven't in the past, we were looking at high level things. It is not whatever the cost share requirement is. We don't have this going back, and I don't ‑‑ it would be pretty complicated to view.

>> CHAIR PROFFITT: Okay.

>> PATRICK KLEIN: A lot of time went into getting this for 2023. I could reach out the team that put it together and see if there's any historic fiscals or what we could do to come up with something. Yeah, it's not something we have ad our finger tips.

>> CHAIR PROFFITT: Yeah, if it's something we are able to do, I think it would be valuable. We can agree with the numbers on the and what it represents, there's a larger philosophical debate to be had. So I think if it's attainable easily, without hundreds of consulting hours, we could benefit from that. Commissioner Schmidt.

>> VICKI SCHMIDT: Yes, Mr. Chairman, I would be interested in more of what Director Flory has said about the differences in the plan, if you could either Director Flory or Segal, put that into the ‑‑ what the differences are in the cost sharing. I also think that, you know ‑‑ it is a philosophical debate, without a doubt. I think one of the other things is when I hear things like, well, when the patient ‑‑ when our employee has the opportunity to choose a lesser priced generic, they're going to do it. Well, there's also the third party in that is the physician. And the prescribing. If the physician says this is the drug I want you on and the patient says, I can't afford that, I need the cheap ‑‑ I mean, and that's the difference between the philosophical ‑‑ of what the plan is. I mean, I think those are important. Shouldn't take out the medical care professional in that, because I know that when a patient says that, that does strike home with the physician and may not the best drug for them, but it's the one that was less expensive. I'd like that in writing. Thank you.

>> CHAIR PROFFITT: We can definitely get the cost.

>> PATRICK KLEIN: We can get the cost sharing for the different regional plans.

>> CHAIR PROFFITT: Start with that action item as opposed to what I requested.

>> PATRICK KLEIN: You could change that to say you wanted to change it to a $20 copay, bringing the 157 down, it is going to the plan, to make up for that, higher contributions. So it is a big balancing act, what everybody is saying.

>> Professor: Very good.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Any other questions or comments?

All right, hearing none, we will move on to the financial report, tab 6 in your books.

>> Zoom in a little bit. All right, so we are here with data through the end of the year, through calendar year 2023. As you may recall last time we talked about large claims and the medical projection being a little bit higher than projected originally. We had a table there that said basically 2023 through October, we are looking at $13 million more in large claims than we have seen historically. Since then, we have got a report there was a $4 million claim that part ‑‑ most of that's in the data here, so continue to have some bad luck when it comes to large claims, that's what is driving the financials here. But overall, we are looking at a 2.3 percent gain on revenue, a lot of that attributed to higher enrollment from the start of the year to now.

On the cost side, really all the other pieces parts, pharmacy and dental and the ancillary costs, those are all within about a million dollars pretty small percent Deltas, it's really the medical where we are ‑‑ got a 10 percent trend in our assumptions, the 5 percent trend range. So that cost of $5.6 million loss. And when you net it all out, some of that is head count. We have more lives than we originally projected. We have $5 million less than what we originally budgeted, that's how the year ended.

Any questions on year to date?

So now that we have full year, we came back with our trend slides. The so the first slide is looking at enrollment, you can see we have had the historical decline in enrollment and in 2023 we jump back up, and I believe there's growth from 23 to 24 as well. So enrollment and then the medical claims, these are all on per capita basis, we are at 10 percent in the last year. It's been a little bit of a roller coaster because you had COVID here in the mix where 2022 you had a decline and then 21, all those services came back, you had a double digit trend. Last year we had a big gain on medical. So there's been quite a bit of fluctuation there if you average it out over the five years, like an effective trend rate, 4.1 percent. Which is pretty close, a little bit under the ‑‑ what we have projected. Long term.

Flipping over to pharmacy, also a lot of fluctuation here. We had some low trends and then came up. Last year we were almost at 20 percent. Had a big loss on pharmacy last year. Now, and this is a big function of the RFP, you have a lot of savings enhanced rebate guarantees, discount guarantees, those all flowing into the financials. So we are at 1.5 percent trend. Again, we were pretty close on our gain/loss. That was factored into our projection originally. Dental, same situation with COVID. We had a big decrease and then an uptick when it came back. Dental is typically pretty steady, the last two years have been 2 and 2.7 percent. Not as much volatility in the dental claims than medical and pharmacy.

Won't spend a lot of time here since Jennifer talked about the enrollment changes. Again, from our original budget, what was projected at the beginning of the year, we have seen about 450 more lives, that's 1 percent growth on the enrollment. Here's our snapshot of the current head count.

So multi‑year projection, we have added a year, out to 2028 now. If you look at the different pieces, it's really the medical trend, those claims coming through were also increasing our baseline, that flows into the future year projections, seeing an increase in medical claims and me out years as well, slight increase in pharmacy. Dental is steady, saw a slight increase there. The one thing we added this time to the exhibit, we wanted to go back now that we have three years and compared our budget actuals. We are looking at what we originally projected for the budget, the actual and gain/loss. Again, kind of bounces around year to year, we wanted to look at it over the last three‑year period. So up top we have a revenue overall, we are about 1.2 percent gain, so higher revenue than projected. Then on the expense side, about 1 percent loss. So overall, on our net gain ‑‑ net cash flow, we are $2.2 million off from budget actual over those three years, that's .1 percent.

Again, lot of fluctuation but long term the numbers are coming in about where we project.

Funding and reserve section, last time when we are solving for the future funding increase that starts at 2025, it was 6.2 percent, the large claims at the end of the year, the increase in the medical trend, now up to 6.9 percent.

This last report we had a sensitivity trend on what happens if there's a million dollar gain or loss in the experience period, how does that impact the 6.9 or future funding increase. So now that we have another year, if you remember last time the Delta between million dollar loss and a million dollar gain was like .4 percent. Now it's down to .2. The reason is we added the extra year, kind of solving ‑‑ you have another year to spread those gains and losses out over.

So that's the end of the report on what I planned to talk about. I don't know if there's any questions.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman. On page 130, I think it's toward the end. Yeah. Those first three columns are the same as the three columns, I'm trying to understand what you're trying to show me there when those numbers are exactly the same.

>> Typically we would have ‑‑ partially through the year, that would show your year to date, let's say we are back in the last report, January to October. So now we have two more months. So we have a full year. So yeah, those sections are ‑‑ they should be exactly the same because we have a full year.

>> VICKI SCHMIDT: Just didn't seem like ‑‑ I was looking for the differences and I'm going like I don't see any.

>> PATRICK KLEIN: Probably could have hid those columns, that was a little repetitive. That's the reason, typically it doesn't show that way.

>> VICKI SCHMIDT: Okay, thank you, just only on the year end.

>> PATRICK KLEIN: Yes.

>> VICKI SCHMIDT: Okay, thank you.

>> CHAIR PROFFITT: Any other questions or comments?

Hearing none, thank you for the report.

>> PATRICK KLEIN: Thank you.

>> CHAIR PROFFITT: All right. Commissioners, before I talk about the next scheduled meeting, do you want to draw your attention to tab 7 in your books, appendix material that staff has pulled together from the December meeting. Also an EAC and Employee Advisory Committee report from the August HCC meeting, published.

>> AUDIENCE MEMBER: Its. Specific to the follow up items, on page 136 ‑‑ published audit items. There was discussion at our last meeting about where we rank relative to our peers for lifetime orthodontic benefits as well as annual and max on dental. The information is provided there. Why then on page 137, should the Commission decided to make a change to either of those, you can see what the costs would be for 1 percent, 2 1/2, 5 percent increase specific. I don't want to take any action on that right now, but just as we are willing towards the August meeting the plan design, just want to make sure we have access to this information, if anybody has an opinion on that for down the road.

Would note that our next meeting is scheduled for April 9, 2024. As a reminder, that is a slight deviation from the original schedule. It's been on the books. We talked about it at the last meeting.

Any questions or closing comments before we move to adjourn. Commissioner Schmidt.

>> VICKI SCHMIDT: I do have a question on the follow up section on page 142 and 143 on the member utilization. I have asked for this before. I just ‑‑ I would like ‑‑ I think those are on the member utilization from 2019 to 2023, on the visits and also the member utilization breakdown, on page 143, I would like the unique number of patients, not just the total number of visits, but the unique number of patients that those numbers represent.

Then the last thing I have is we received a complaint through the department that I am ‑‑ I didn't check on this, but fairly certain it was state employee health ‑‑ state employee that filed the complaint. We send those on. But this one was very curious to me. This complaint mentioned that the State Employee Health Plan had signed on with a company called Prudence.

>> JENNIFER FLORY: It's Prudent RX.

>> VICKI SCHMIDT: Did we approve that contract.

>> CHAIR PROFFITT: We did, that was done at the HCC meeting you were not here there.

>> VICKI SCHMIDT: It looks like there's ‑‑ well, okay then, I will ‑‑ I will ‑‑ I'll contact you later about this because I think there's ‑‑ there seems to be an issue with the crediting of copayments and ‑‑ that copayment not coming all the way through the system.

>> CHAIR PROFFITT: If you can send the specific on to staff.

>> VICKI SCHMIDT: I think we have sent it on, I don't know what Prudence was. I'm like what is that. Thank you, Mr. Chairman.

>> CHAIR PROFFITT: Absolutely. Any other Commissioners with I in comments or questions?

Commissioner Cain.

>> CRISTI CAIN: Can I share a quick story.

>> CHAIR PROFFITT: Long it's not about me.

>> CRISTI CAIN: It's not. I have a colleague who gave me permission to share. She received a skin care screening because it was an incentive that we implemented last year, and they diagnosed melanoma and she was successfully treated. I just wanted to share that, that she said without it being an incentive, she wouldn't have gotten a skin cancer screening, I thought that was a great story.

>> CHAIR PROFFITT: Thank you very much. I'm glad there's a happy ending there. Thank you for sharing.

Any other questions or comments?

Okay. Hearing none, I would entertain a motion to adjourn.

>> VICKI SCHMIDT: So moved.

>> Professor: Is there a second. Commissioner Cain a second. All in favor, say "aye."

[ chorus of ayes ]

Any opposed? We are adjourned. Thank you very much.