

ROUGHLY EDITED TRANSCRIPT
STATE OF KANSAS
KANSAS SEHP MEETING
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>> CHAIR PROFFITT: Good morning, we'll call this meeting to order, it is 9:36 a.m.
It's also April 15.
So if you haven't already, get your taxes in.
It is that time of year.
Exactly.
The budget guy.
All right, this is our first meeting for a couple of months, I appreciate everybody staying with us, appreciate also the commission staying with my moving things around and landing back to the original date.
We are right in the middle of revenue estimating, in my other job, I have lots of meetings all day long.
Here we are.
At any rate, we do have a quorum, we'll get going.
Actually, first, thank you again to KPERS and their staff for allowing us to come here and providing us with all the healthy food over there.
First item of business is to approve the minutes from the last meeting, those are in tab 1 of your book.
Any amendments to the minutes?

motion by Commissioner Sutton to

>> Professor:

>> STEVE DECHANT: Second.

>> CHAIR PROFFITT: Any discussion, all in favor, say "aye,"

[chorus of ayes]

any opposed, minutes approved.

Moving to tab 2.

This is probably the bulk of the meeting here today.

We are going to review the bids for the ASO contracts, beginning of plan year 2027.

These are in tab 2 of your books.

We are going to have Segal walk us through the presentation, introduce yourself for the record, please.

very good, thank you.

Is your blue light on, bright blue light?

okay.

But it's on.

Just wanted to make sure.

>> Now it's very blue.

Now it's significantly blue, okay.

>> CHAIR PROFFITT: Significant, thank you.

>> Yes.

Can you hear -- do I need to announce myself again or did everybody hear me.

>> CHAIR PROFFITT: You're fine.

>> This will be interesting this year.

Things are a little bit different.

So let's go to the agenda on the next page.

I'll just sort of introduce what we did, the key requirements, review the process, look at the differentiators and as you see, the differences in costs.

So moving on to the introduction slide.

of course the state offers comprehensive benefits to approximately 43,000 eligible employees.

They're about just under 40,000 enrolled with 4500 in the Aetna plan and just over 35,000 in the Blue Cross Blue Shield plan. These proposals are for January 1, 2027 effective date, and would be for a three-year contract period.

next slide.

key requirements for this RFP were to be able to administer the plans as they currently are, the current plan designs.

Offer a nationwide provider network.

Meet all of the security requirements, have the work performed on shore, inside the U.S., provide complete administration support for anything that would go along with processing the claims and managing the plans.

Next slide.

the review process is listed here, we looked at network breadth p depth across the State of Kansas, as well as nationally.

The cost would be the administration fees, met network discounts and the access, any cost containment programs, the ability to meet the requirements you saw in the previous slide.

The ability to support the services, including printing and mailing ID cards, member services, ability to process all member claims and provide tools and resources for navigation.

And also have an employee portal.

Next slide.

this year, again, we had only the two current incumbents respond.

I think last time we had an additional one.

So this year it was just the two incumbents.

And so we met with them and they continued through the process.

Let's go to the next slide, get the meat of this.

So here's the network access by region.

Of course, region 1 is the largest around the Kansas City area, and region 5 is the second largest.

And you can see -- the vendors were asked to provide the number of these types of providers here, hospitals, mental health, primary care especial and mental health providers.

The first mental health I mentioned was facilities.

Mental health and substance use facilities.

So they were supposed to give us the number of each unique provider in each region, each county in each region.

So if a provider had three offices, we at the want them listed three times, we wanted to just know there was one provider in that county.

So as you can see in the hospital line, Blue Cross Blue Shield has a few more hospitals in their network.

The mental health and substance use facilities, Blue Cross has a few more in their network.

Primary care, Blue Cross Blue Shield has significantly more primary care listed in their network.

When you move to specialty, Aetna has significantly more specialists in their network and mental health providers in their network.

Going to the next page.

This next page just shows basically that both carriers have a significant level of access to their providers in the network.

Network penetration.

This was basically -- this particular grid was based on dollars spent, so people are spending the majority of their dollars on -- in network providers.

Aetna's ancillary group was the lowest, and the ancillary is diagnostic imaging, lab work, physical speech, occupational therapy and various custodial care.

Next page.

The in network discounts here are split out by place of service and the top section that says in network are actually the negotiated contracted discounts that the provider -- that the vendors have with the providers and the facilities.

The bottom level, even though it's showing you percentages, these aren't really discounts, but it's more based on how the carriers reimburse out of network physicians based on community rating, geography kind of things, maybe a percent of Medicare, they all have various different types of reimbursements and methodologies.

The bottom row is the net effective discount, basically what you would see or expect to see in your claims for processing in and out of network.

next slide.

>> CHAIR PROFFITT: We have a question, Commissioner Schmidt?

If you could hold to the end, make sure it doesn't get answered as we go.

>> VICKI SCHMIDT: Okay.

>> They currently have a blended administration fee, so, you know, you have 35,000 people with Blue Cross and 4500 with Aetna.

So we blend the fees, and these are the proposed fees that would be 3304.

Aetna's ASO fee is based on a level of enrollment.

So with this lower enrollment at the 4500 level, the ASO fee is 3575.

So if they had 30,000 or more, the ASO fee would be 2485PEPM.

So this is -- this page is just reflecting the current blend of enrollment that they have.

so the 3575 for Aetna, the 2374 Blue Cross Blue Shield, based on 35,400 employees and your blended rate for 3 years is 3304 PEPM.

Next slide.

Okay.

So as of February, there were just under 40,000 employees.

So we took the net effective discounts and this first column is the baseline.

So that's where you sit right now, based on the baseline data that was submitted.

Your effective discounts are about 72.6 percent.

That's a blend of Blue Cross Blue Shield and Aetna.

So the next two columns are keeping the same blend, assuming the same blend of

lives, enrollment, and then the last three columns, excuse me -- the last three columns

look at the scenario of Aetna only with either of their networks or Blue Cross Blue Shield only.

Taking over the whole population.

So the network penetration is very high for both.

But Aetna's discounts have increased significantly over the years. They were up a little bit last time we went through this process and they're up significantly again this time. And they are proposing also a local best network which they say is the same providers and facilities that they have so there's no change in the providers in that network, but the in-patient and outpatient discounts are significantly deeper, and these are primary in the -- primarily in the Kansas City area. Which is where the greatest portion of your population is. Going back to the grid, the projected paid medical claims, and you'll see these claims listed in the financial report also, then we apply the differential in the discounts to that to get the adjusted paid claims. These adjusted paid claims take the projected paid claims and adjust for the differentials and the discounts. And then we add the admin fees and of course the first -- the 2027 blend or the blended proposed and then the next three are vendor specific. The total claims and then of course this yellow line down here at the bottom shows the different from current. Though if you kept the same current blend with the CPOS2 network, it would be a 3.21 percent increase in cost. If you go to the local best with Aetna, same blend, 2.74 increase. Aetna only, you see that saves some significant dollars, you would save 6.59 percent if the local best, down 11.97 percent and Blue Cross Blue Shield only would be up 4.29 percent.

next slide.

this is the 3-year cost summary. We dropped the baseline off since that wouldn't be for three years. So the two columns here at the beginning are the blend the current enrollment. And with the local best. We used the current network as the baseline here for judging the rest of how the three-year rolls off. So the three-year first column is if -- if you stay with the current blend of Aetna and Blue Cross Blue Shield with Aetna's CPOS2 network, which is what use have now for three years, 1.5 million.

the next column, local best shows you how the local best compares to was have now, that saves you almost 7 million. The -- moving over to Aetna only with the currently network you have now, CPOS2, local best. 221 million down. These are Aetna only, and Blue Cross Blue Shield only is up 15.8 million.

and for theses three-year projections, we assumed the 5.5 percent trend you'll see in the financials also.

Next slide.

we had some additional fee negotiations with the vendors.

So there are several things in here that are based on percent of shared savings.

So Aetna agreed to come down on their national advantage program, which is kind of a silent wrap network for claims that fall out of network.

They have the national advantage program, where they can negotiate with some of the providers that these folks may see to get a discount and then they typically would keep 40 percent of the savings that they negotiated and they agreed to drop that to 30 percent of the savings.

And cap the individual claims at \$100,000.

Blue Cross Blue Shield agreed to reduce the shared savings for the smart shopper program from 32 to 27 percent of savings with a cap of 100,000, and Blue Cross Blue Shield has negotiated some custom administrative expense allowance for claims that are incurred in the blue Kansas City area.

These fees were 975 per institutional claim and they they've reduced that to 825 per institutional claim.

And four dollars for professional claim reduced to 325 for professional claims.

And the blue kc area accounts for about 97 percent of the total administrative fees for these types of products.

So that's a lot of claims that would be coming through at the discounted rate.

Blue Cross Blue Shield agreed to place a 450 Pcp cap on the total patient medical centered patient home value fees.

This is a program where if providers meet certain metrics, various outcomes, get the gaps in coverage covered, make sure people that have their screenings, all that type of things, they get additional payments, bonus payment if they meet their target.

And the costs have been going up over the years for the out of area.

In state used to be higher, those are going down, we are paying more out to providers that are out of it service area, primarily, of course, in the Kansas City area.

So they did agree to cap that.

Okay.

This first slide of key differentiators is Aetna.

Though Aetna's discounts are quite a bit higher, significantly greater than Blue Cross Blue Shield's discounts, and Aetna is offering an annual health plan allowance to help offset various expenses that might be associated with the plan.

Member education, communication, wellness fairs.

So for this level, if you stuck with the 4500 enrolled, that amount would be \$130,000, but if they took over the full account, it would be \$1 million.

For the year.

The SEHP could use to offset some expenses.

And they are current vendor, so for 4500 members.

But there would be no disruptions for the current group that's enrolled.

However, there would be quite a lot of disruptions if they replaced the whole program because 35,000 people are in the Blue Cross Blue Shield program.

And a lot of these folks are in rural areas that Blue Cross Blue Shield may have more

primary care out in those areas and a handful more hospitals.

So the cons are a couple of their metrics in the performance guarantees are tracked on book of business level rather than your specific data.

Next slide.

Okay.

So Blue Cross Blue Shield, when they noted something was included -- there were a couple of things, let me preface this, on the Aetna cost sheet, there were a couple of things that said included that were not necessarily included in the fee but expected to be covered by the health fund that they were going to allow the group to have.

So that would be an automatic offset to that already.

So Blue Cross Blue Shield, when they noted a service as included, it was truly included in the ASO fee.

They're also offering an annual general fund, similar to the fund that Aetna had provided.

The Blue Cross Blue Shield is 500,000 to be used at SEHP's discretion.

All of Blue Cross Blue Shield's performance guarantees are SEHP specific, they're not based on book of business.

And they are a current vendor so there would be no disruptions for the majority of the group, the 35,000 employees.

Some of the cons are that Blue Cross Blue Shield has lower net effective discounts and their fee is up 7 percent from the current fee, but that's due, primarily, to requesting a 3-year flat benefit.

So if there was an escalating fee prior to this, and the SEHP wanted a flat fee for 3 years.

So both vendors proposed a flat fee so it's a starting point a little bit higher because they took what they needed for the three years and blend over the three years.

There's also an appendix, do we need to go through that?

Okay.

>> CHAIR PROFFITT: No, thank you.

Thank you very much for that.

We'll move on to questions.

Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you, Mr. Chairman.

Jennifer, right?

>> Gina.

>> VICKI SCHMIDT: Sorry, sorry, Jan.

Okay, back on page 17, what -- can you -- I don't understand the discount, is that the -- what is that discount?

>> The top section?

So the top -- this top section, so the discount is the difference between the eligible amount, so a provider will submit a bill for -- let's say you go to the dermatologist, and

he looks at you, you have your normal exam, he might take off a mole that looks suspicious and that would be medically necessary, but you say I don't like this mole over here and so take that one off while you're at it, that's cosmetic because there's nothing wrong with that one.

When the bill comes through, he has to code it a certain way.

The one that you had removed cosmetically would not be eligible for coverage.

That would drop off.

So the bill comes in and then you have this not covered amount.

So that mole would not be covered.

You have the eligible amount.

That's the eligible amount that's available to be paid by the member and the plan.

And so the vendor contracts with this dermatologist and says, okay, you sent this bill in

for \$200, and \$25 isn't covered so the eligible amount is \$175, but we want to

negotiate -- in your contract, you've agreed to charge just \$100.

The discount is the portion between the 175 and the 100.

>> VICKI SCHMIDT: Okay.

Negotiated discount.

>> Negotiated discount.

So this top section is the negotiated discounts and this bottom section really isn't discounts, but you can see that it's off the charges just because of the way that the vendors reimburse the various methodologies they have of reimbursing out of network providers.

So they're going to pay them less and shift it more to the members.

>> VICKI SCHMIDT: Okay.

So it's kind of the write-off.

Okay.

Okay.

On page 19, I don't understand that if the Blue Cross Blue Shield -- I'm looking at the estimated administration fees, and the Blue Cross Blue Shield only is 15.6, and the Aetna only is 11.8.

How does the blended equal more than the highest of the Blue Cross Blue Shield?

>> This goes back to what I was saying before.

The blended -- the Aetna ASO fee is based on level of enrollment.

If you look in the appendix on slide 26, page 26 in your packet.

So this blended used the 3575 because they only have 4500 people enrolled.

Excuse me, in their billion.

But if they were the only carrier, they would have more than 30,000 plus and the ASO fee would be 2485.

Do you see bottom.

>> VICKI SCHMIDT: I guess I still don't understand that.

How can the blended rate be more than each one individually.

>> I'm using a different rate, a different fee for Aetna for the blended versus the Aetna only.

Because the Aetna only would be based on 30,000 plus enrollees, which is that lower 2485, which is 30 percent lower than the 3575.

>> VICKI SCHMIDT: I think that's kind of confusing.

And then the asterisk, I really need you to explain the asterisk.

Administrative fees represent only the core for employee per month fee, they do not include attribution fees.

Will what is that?

>> It's like a capitated rate if you -- this goes back to some of that value based stuff.

So if you have an ACO type of arrangement -- some of them have a special arrangement with some of the providers, so that if they meet these metrics, you know, they get this value based bonus, but the attribution means that somebody is seeing that provider regularly.

So they may -- they have various methods for saying attributes.

Attributing somebody to a provider.

If they see somebody two or three times in a row, they consider that member attributed to that provider.

Like must be their regular provider, you're attributed to that provider and so they are paying some level of capitation usually for that.

They might pay that provider \$5.50 per member that's attributed to that provider.

And a lot of that's folded in with the value based payments now and the blue card fees.

What I was saying in this annual admin fee piece, is that a lot of these fees down here at the bottom that I listed, the value based, the blue card, some of these other fees that we talked about them negotiating that are based on percent of savings, we don't ever -- don't always have a way of quantifying that to put it in here.

Those flow through the claims wire and they vary by year.

So we stuck with what was fixed.

>> VICKI SCHMIDT: Would the majority of those increase per employee per month or would they decrease our amount that we are paying.

>> They used to the cost because they're additional fees that aren't charged on the regular ASO fee invoice that you get that's a PEPM amount.

These are charges that are not claim charges, but they flow through the claim wire.

They usually have a different code.

>> VICKI SCHMIDT: Surely you have history on those?

>> They have been pulled before.

Do you have a number that you.

>> VICKI SCHMIDT: I don't have a --

>> I don't have a specific number on that.

The if you look on the chart on page 21, we are showing you for the patient centered medical home part of it, if you are attributed that your regular physician is part of that

program, these are what we have paid the last three years and what Gina was pointed out is that most of the additional fee in the, quote, out of area is the Blue Cross Blue Shield of Kansas City area for patients in that particular area. And then the in state is obviously the other 103 counties of Kansas.

>> VICKI SCHMIDT: Still on page 21 it says Blue Cross Blue Shield will 450 per employee per month cap on that.

We ought to be able to estimate how many people are in -- how many people have we served or do we serve in that and used that to this amount?

I mean, I think what bothers me is you're asking us to vote on -- you're asking to us decide which way to go with a contract, but the numbers aren't even the total numbers.

>> The numbers are that additional are -- they vary every year, they're close, with but they're not something I can quantify necessarily.

I can get some information maybe from the vendors who can tell me how much has gone through the claim wire, but it's going to vary every year, so I can point out what that is, but it's.

>> VICKI SCHMIDT: We don't even have that variance here, is that variance \$3 million or \$10 million?

>> It's not \$10 million.

>> VICKI SCHMIDT: Is it 3?

>> It might be 2 to 3.

It might be.

>> VICKI SCHMIDT: That's significant.

\$3 million on top of 15 is significant.

So I just don't think -- I'm disappointed that we don't have the information that I think we should have.

I don't think that asterisk should be allowed to be there about we just don't know so we'll give you -- I can do the simple math of the per employee per month, and I -- well, okay.

May I go on or does somebody else.

>> CHAIR PROFFITT: Director Flory, did you have something to add.

>> JENNIFER FLORY: We did have quite a few conversations with Blue Cross Blue Shield about the primary care medical home piece, because the prices have varied, and we saw this big swap this year in the out of area portion, which is Blue Cross Blue Shield of Kansas City, which we don't get any reporting on that.

In their bid they did show that the in-state saves about .5 percent because those employees that are seeing a primary care medical home are more likely to get their preventive care fee.

We did ask them that if you all did not wish to continue to participate in that program, that they can eliminate that from their bid and it will not affect the other portions of their bid.

The pricing of their ASO fee won't change if you decide you don't want to have that primary care medical home piece anymore.

>> CHAIR PROFFITT: What would the impact to the membership be if we eliminated that?

>> JENNIFER FLORY: It really doesn't affect the membership because this fee is paid to the provider.

The so as Gina mentioned, it's so that the providers that are participating in this program are ones that are complying with the measures, so like for example, if I have diabetes, they're making sure that I get an annual eye exam, get appropriate foot care, that I'm prescribed a Chester old lowering medication because I have diabetes.

It is making sure you hit those metrics, making sure that your female population is getting their mammograms, that people over a certain age are getting colonoscopies, incentivizing those providers when Blue Cross Blue Shield runs their reporting, they are complying with those measures, and for that, then they receive this additional payment each month, which -- they have capped that at 450.

This is the first time we have had that cap.

This was new with this contract.

Am does that help.

>> CHAIR PROFFITT: It helps, thank you.

Mind if I move on, other Commissioners.

>> VICKI SCHMIDT: Can I follow up on this real quick.

I just want to make sure I understands.

We provide a provider \$4.50 per employee per month to be in this medical home plan.

>> JENNIFER FLORY: If one of our people is attributed to a provider who is identified in the primary care medical home program meeting those metrics, yes.

>> VICKI SCHMIDT: Personally, I don't think my physician would not give me cholesterol medication for \$4.50 additional fee they could charge.

But that's just me.

Thank you.

>> CHAIR PROFFITT: I think I heard Director Flory say we could opt to not have that as part of the plan.

>> VICKI SCHMIDT: I'm just saying \$4.50 a month isn't a game changer for a physician.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: Related to the discussion we've been having.

This only applies to Blue Cross Blue Shield, not Aetna?

>> JENNIFER FLORY: That's correct.

And it's also -- it's the Blue Cross Blue Shield not only in the 103 counties, but there's also a similar program in the Kansas City area that we are paying for, for this primary care medical home.

>> STEVE DECHANT: Going back to page 15, network access by region, curious, have those numbers changed significantly from current contract to the proposed?

>> This year there are a couple of different categories in here. The -- there used to be just one category that said behavioral health. Now it's split out by mental health and substance use facilities, and mental health providers. So those are two new categories, the hospitals, the primary care physicians, and the specialty physicians are the same categories that have been in there for several years now, and Blue Cross Blue Shield, the primary care numbers are up some. The Aetna numbers are up a little bit from where they've been in the past, but still considerably lower than Blue Cross Blue Shield. The specialty physician number for Aetna has gone up quite a bit. So that is quite a bit higher than what we have seen in the past. And the mental health providers I see a new category. So that's higher also.

>> STEVE DECHANT: Thank you.

>> CHAIR PROFFITT: I have a question on page first think it's on page 17 but kind of throughout as it relates to Aetna.

You noted there are two plan options, what we currently have and the local best. I think I heard you to say there are really no differences between the two, just the discount rate.

I want to make 100 percent sure there is zero differences, no change in ASO fee and provider network, no change in covered services, literally no change, I can buy this blue jacket for \$20 or this blue jacket for \$15, no difference whatsoever.

>> Correct.

>> CHAIR PROFFITT: We can choose to pay more or less and there's zero percent difference to the membership, to the plan, to the cost, at the network to anything whatsoever?

>> Correct.

>> CHAIR PROFFITT: Commissioner Sutton, you might have a question that I would have as a follow up.

>> BILL SUTTON: Thank you, Mr. Chair.

This is indeed a follow up.

If the two -- excuse me, if the two are identical, why are they both being presented?

>> I think the local best -- the local best is new, so they have negotiated additional discounts on the inpatient and outpatient charges.

Basically the facility charges.

>> BILL SUTTON: New since the response to the RFP?

>> New since the response to the last RFP.

>> BILL SUTTON: Oh, okay.

So we are comparing current versus the new and improved?

>> Right.

Your current is the CPOS2 and the local best is another new -- a newer network that they've negotiated.

>> BILL SUTTON: Okay.

Clear as mud.

>> Okay.

>> BILL SUTTON: Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: Want to make sure that I'm understanding these numbers.

On page 20, so on page 20, if I look at the dollar change from current dual network offering, if Aetna CPOS2 only were to be awarded the contract, the plan would save 142 million over three years?

>> Correct.

>> VICKI SCHMIDT: Do you believe that Aetna has the primary care network that would be sufficient for the state then, the state employee network?

>> I think that they are lacking in some of the rural counties.

>> VICKI SCHMIDT: Okay.

Yeah.

Okay.

>> If you go back to slide 15,s you can see in some of the regions and we can give you the by county detail, also.

>> VICKI SCHMIDT: Okay.

You know, Segal does a lot of this type of work in a lot of states.

So how does this per employee per month fee compare to similar sized groups?

>> It's comparable.

>> VICKI SCHMIDT: With the 145 million-dollar difference, which one is comparable?

>> The discounts are what's driving the difference, not necessarily the fees.

It's the -- the fees are significantly lower, but it's the discounts that are impacting the claims that are driving the difference in the cost.

In the overall cost.

>> VICKI SCHMIDT: Okay.

I wrote down what you said on page 21 about the national advantage program, but I don't think I understands it.

Claims that fall out of network and who keeps the 40 percent savings?

>> The vendor.

The vendor keeps the 40 percent of the savings that they negotiate, but they've agreed to come down to holding only 30 percent of the savings.

>> VICKI SCHMIDT: On the smart shopper program with Blue Cross Blue Shield, the patient keeps the difference?

>> No.

The vend.

>> VICKI SCHMIDT: The vendor keeps that difference?

Are there any studies on outcomes for I choose a smart shopper -- I'm a smart shopper shopper and I go to a provider that is more economical, does the smart shopper get to see the outcomes of those?

The --

>> Theoretically they get better quality and better outcomes on their health.

They don't necessarily see better outcomes in their payment and their cost.

>> VICKI SCHMIDT: I'm talking about the outcome, the medical outcome.

If I go -- am I going to have a higher risk of infection if I have a surgery by somebody that's discounting it 35 percent?

Then am I going to have -- does that surgeon have more complications than the one that is not.

>> I know what you're saying.

>> CHAIR PROFFITT: I might interject.

I don't know that Segal would be the appropriate entity to answer that question.

Might be better for the tpa's to answer that. I think Director Flory might have it.

>> JENNIFER FLORY: The smart shopper program is one that the state put into place, I don't know, 2017.

This was discussed a lot at the legislature, this was a program that at the time the director went over and met with the committee and they wanted us to try introducing some kind of a program that incentivized our employees to use the most cost effective providers.

So we have a list of services that you can shop for, things like mammograms, colonoscopies, knee replacements. There's a whole list available out on Blue Cross Blue Shield's website.

A member can either go out and shop on the Blue Cross Blue Shield website to find a provider and then have the service provided by them, or there's a phone number and they can call the smart shopper program and they have a kind of a concierge type of customer service that can talk with you about what your provider is recommending, what services they're recommending, they can look at the network of available providers, and talk with you about which one might be the best choice given what the services you're looking for, and if you then use that provider, the concierge will actually help you get an appointment with that provider to have the service done.

After the service is done and it's processed through the medical plan, then there is -- on the list, it will show you what the potential incentive payment was to the employee for

selecting that cost effective provider and Blue Cross may be able to chime in because I think there's a little bit of an element of quality that goes into that, but I'm not probably the best person to speak about it.

And I would prefer we have representatives here if you would like them to provide you more detail.

>> VICKI SCHMIDT: Well, I thought that you said that the savings goes back to the vendor.
Goes back to the patient?

>> JENNIFER FLORY: There's a savings amount is that right on the website where you can see if I go to the mammogram provider listed, after I've had the service and it runs through my health plan, I will get a \$25 check.
The difference between what typical facilities charge and what the low cost vendor charges, there is a savings calculation in there that we pay as an administrative cost for that program to -- smart shopper who is the vendor providing the service.

>> VICKI SCHMIDT: Do you know how much we pay for smart shopper?
Do you know how much we have paid in the past?

>> It's not super widely used.

I think monthly when we see the bill, I think our payment to them is generally around 5,000.

Not even -- Paul says not even \$5,000 a month.

It's an incentive program to encourage employees to shop.

Again, there have been a number of bills over the years with the legislature, this was one that there was discussion with the director at that time, and the secretary of administration at that time, and the decision was to try operating one through the health plan.

It wasn't really -- the bill doesn't pass, it wasn't something we had to do a report back to the legislature, it was a conversation of cooperation that we took on to ask our vendors to offer that kind of program and so it's been in place for the last six years.

>> VICKI SCHMIDT: Do you think it has saved?

>> Yeah, for the employees that use it, yes.

The they get a little savings check and the plan saves a little money.

Again, we haven't been able to get wide utilization.

One of the challenges we face is being, as everybody in this room knows, a stay with urban and rural providers, is that it's a lot more challenging if I live in -- I need a mammogram, the low cost provider may not be an option for me simply because I don't wish to travel that far to get to it.

We have had both Aetna and Blue Cross Blue Shield have a program that does this, and it's just a challenge sometimes to find a provider.

I know, for example, I was looking for a friend who was looking at having a hip replacement, and it was recommending that this person go to Manhattan.

Well, this Topekan, all their family was here and all their support was here, so going to

Manhattan, even though that was a low cost provider, it wasn't something they were willing to do.

Our utilization is pretty low, but we do save when an employee uses it.

>> VICKI SCHMIDT: The \$25 goes to the gas?

>> Yeah.

>> VICKI SCHMIDT: Not even that now.

>> Pretty much.

>> VICKI SCHMIDT: You might have to think about that.

Okay.

All right, thank you, appreciate that explanation.

Can you explain the difference on the book of business level and the client specific level?

The book of business is more than just our group, right?

>> It's their whole book of business.

>> CHAIR PROFFITT: Can you explain that.

>> All of their clients.

>> CHAIR PROFFITT: Explain that.

>> It means all of the clients for which they provide services for as their clients, that they provide these.

>> VICKI SCHMIDT: This goes back to our.

>> JENNIFER FLORY: With Aetna, we only have a small enrollment of 4500 people.

So we don't necessarily have a dedicated customer service center like we do with Blue Cross Blue Shield where, when our employees call Blue Cross Blue Shield today, they're speaking to somebody in the Blue Cross Blue Shield State of Kansas customer service center.

With Aetna, some of those services are actually done in a facility where they're processing other employer stuff.

Because we are not very big -- our population with them isn't very big, we get book of business numbers rather than specific just to the state.

>> VICKI SCHMIDT: Okay.

And back to the primary care -- I think we are talking about the primary care and the one district 6, I think, or zone 6.

Has Aetna -- have they been increasing the primary care physicians in that area or do you have any --

>> 15.

>> CHAIR PROFFITT: Would you like for Aetna to come up and address that question.

>> VICKI SCHMIDT: Just whoever wants to answer it.

>> CHAIR PROFFITT: Come to the microphone, please, and introduce yourself.

>> I'm Kendra plaque with Aetna.

-- Kendra black with Aetna.

yes, just confirming here.

It looks like, based on what we provided in our last RFP, we are down just a little bit from where we were.

We had 5700 and we are now at -- I'm sorry, prior to in 2023 we had 4500, and in 2026 we have 5700.

So we are increasing our primary care providers, and we are always looking to negotiate and bring in new providers.

It's a process.

We have high quality assurances and are negotiating in contracts.

So we don't allow just anybody in.

We make sure that they are qualified, verified and meet our requirements.

We are always looking to bring in new providers.

>> CHAIR PROFFITT: I think the answer you quoted, I don't want to speak for you, it looks like the number you quoted 5700 was state WIOIA.

I think the question was about region 6 specifically.

Commissioner Schmidt, 251.

>> I'm so sorry, and for that, we did have 172, in 2003 and then we currently have 251.

So it is increasing as well.

So thank you for pointing that out.

I was looking at overall.

The.

>> VICKI SCHMIDT: So could your company absorb all of the employees throughout the state, including the rural areas?

>> Yes, I am confident we can.

>> VICKI SCHMIDT: Okay.

Thank you.

>> CHAIR PROFFITT: Any other.

>> VICKI SCHMIDT: One last question.

>> CHAIR PROFFITT: Okay.

>> VICKI SCHMIDT: On the cons, on page 23, Blue Cross Blue Shield's proposed ASO fee is up 7 percent from the current 2026 fee.

In your experience with other plans, are they seeing that type of an increase, that's a pretty significant increase.

And yet, you know, I would point out, that's not inclusive?

>> Right.

This increase is because of the way that it's blended.

The initial -- hold on just a second, give me a second, see if I can find the initial three-year -- initially when we asked for a three-year proposal, it was 31.88 for the first

year, 33.32 for the second and 34.82 for the third year.

There was an escalating fee.

So what they did, they took -- what they needed for the whole three years and blended it over the three years, that's how it's lower so -- because it would have gone from the low to the high, it's a little bit higher on the start and held flat for three years.

>> VICKI SCHMIDT: Okay, thank you.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: I'm back on page 15, I guess also looking at 20.

I don't know who to ask to respond.

Just do some quick math in my head.

Between primary care and specialty physicians Aetna has right at 30,000.

Give or take a little.

So does Blue Cross Blue Shield.

But the big difference is that the specialty is much higher as Blue Cross Blue Shield and vice versa.

So I'm wondering, what -- the total physician numbers between primary and specialty are roughly equal.

But there's a tremendous difference in primary care, of course that happens -- happens across the board through all six regions so what I'd like to hear about is what kind of impact is that having?

Is that going to drive me as a customer to seek out a specialty provider almost as a primary since there's a smaller number in the Aetna group.

What impact would that have.

>> JENNIFER FLORY: I think if you look at page 25, you'll see that Aetna and Blue Cross did not categorize what they consider a primary care physician and what they consider specialists exactly the same way.

The so.

>> STEVE DECHANT: What's that tell us.

>> JENNIFER FLORY: It tells us some of the ones listed as primary care under one are listed specialists under the other.

>> I think that their primary care is very similar, but their specialist -- they're working on a list for me right now.

Blue Cross Blue Shield provided a very detailed list of all of the specialists types and the behavioral health specialties, and Aetna just said all nonbehavioral health specialists and the specialists in behavioral health providers and the health providers, they are currently working on a more detailed list of what those are.

The primary care physicians are very similar, Blue Cross Blue Shield did list out specifically physician assistants and advanced practice registered nurses.

Which are sort of like nurse practitioners to some degree.

So those may also -- are those included in your primary care at all?

the nurse practitioners, these counts you gave me?

The nurse practitioners, Aetna is saying they're also in their primary care count, even though it wasn't specifically listed.

So they have the same -- they have the same categorization in the primary care category.

>> CHAIR PROFFITT: I think we are getting a follow up, sorry to interject.

>> Correction.

So they are not counted in there.

So maybe we can get a recount for that.

If they list them out.

I do have more detail coming on that.

>> CHAIR PROFFITT: Commissioner Sutton.

Is think that might be helpful to have the ones listed as primary care that are actually PA's or APRN, I think that could change the way the numbers look maybe pretty dramatically, but even without that, I was just looking at the primary care physicians, and in the worst case scenario, I know we were looking at No. 6 because the numbers were pretty dramatic there, but in doing some.

>> LITTLE -- I WASN'T DOING IT IN MY HEAD, I WAS USING ANY PHONE, BUT REGION 3 ACTUALLY SHOWED THE BIGGEST: Discrepancy and even in that, without the APRN and RN's and PA's being listed, in region 3 it worked out to be 22 covered customers per primary care physician, which is not a crazy number.

It kind of lends itself to saying that even without the additional numbers being supplied, it looks like coverage would be -- would certainly be adequate if not as universal as the Blue Cross Blue Shield network.

Thank you, Mr. Chair.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you, Mr. Chairman.

You know, I guess what bothers me is that I remember this discussion three years ago, and we talked about this discrepancy of not defining primary care physicians.

Like if I'm reading this and it's a primary care physician, a physician means an MD or DO.

When you have one that's including physicians assistants and APRN's and one that's not, that's not -- that's not the same comparison.

We -- if we're going to make a decision today, we need these numbers like prawn to, and I also think t mental health providers, what does Aetna include because Blue Cross Blue Shield -- and I understands mental health providers is a much -- a much more -- it's not defined like physician to me, is defined.

So are they including therapists, counselors, social workers and more.

What is more?

I don't know what a more is?

And I have a --

>> I have a list that I can give you, I can give you their detailed list from Blue Cross Blue Shield and Aetna is going to have a detailed list for me tomorrow.

>> VICKI SCHMIDT: But we are here today.

And so when did you ask for that list?

>> May have been Friday.

>> VICKI SCHMIDT: Paid a lot of money for us to have to wait another day.

>> I got their first message and asked for more details. They need a couple of days to get me more detail.

>> VICKI SCHMIDT: When did you make these slides?

>> Last week.

When I got the first.

>> VICKI SCHMIDT: We pay Segal 40 some thousand dollars a month, and so if we can't get these before the meeting, it's not very helpful to me anyway.

Thank you.

>> CHAIR PROFFITT: One comment as a follow up, Commissioner Schmidt.

Are we can debate this at a later point in time, really the PCP, point well taken, there's a large population, myself included, until recently when my primary care provider went to a different organization, my PCP was a nurse practitioner, I believe the APRN and they all practice under the supervision of.

There is a large segment of our population that uses that as primary care.

Point well take.

>> VICKI SCHMIDT: I don't disagree.

We ought to put the provider category differently.

>> CHAIR PROFFITT: I wanted to make sure.

Maybe that's just more personal where I go.

>> CRISTI CAIN: I wondered if it would be possible to hear from Blue Cross Blue Shield, I would just be interested in a brief explanation of why we shouldn't go with Aetna only?

Is that appropriate?

>> CHAIR PROFFITT: More specific question?

>> CRISTI CAIN: I mean I guess I would like to hear the response to the discussion regarding -- like when Aetna was at the podium and talked about how they could cover the whole state and they could take over all of the employees, I'm just curious like what Blue Cross Blue Shield's thoughts are about that?

>> CHAIR PROFFITT: Blue Cross, do we have representation?

we have representation that is willing to answer a question like that?

if you can introduce yourself and come up, please.

>> Good morning, I'm Andrea Larson, avp of sales for Blue Cross Blue Shield.

>> Trina Mason, Executive Vice President and chief sales officer.

>> Thank you for the question.

We have enjoyed a long standing relationship with the State of Kansas and the employees.

We are local, we are right here in Topeka.

We have strong relationships with the team at the State of Kansas, we do provide a lot in our administrative fee, which was referenced earlier as being all inclusive from ad hoc reporting with really no limitations.

All of our marketing materials, postage, it's customized to the State of Kansas, our member services, our dedicated to the State of Kansas as well.

We felt like we came out really strong this year in our proposal, I would like to just clarify that the \$500,000 allowance is a per year, so it's 1.5 million over the three-year contract. I would also like to just reiterate that the -- we were asked for a flat fee over the course of the three years, which is a 7 percent increase, but it is a 3 1/2 percent increase for year one, 3.4 year two and 3 percent over the third year.

We also did include a member advocate as an addition to this proposal, which would allow for a licensed social worker to be embedded into your clinic, if you would like to help with advocacy, as well as access to community resources and education on their benefit plan.

>> The other thing, I would clarify on the value based, on the -- Commissioner had a question about that.

It's -- the 4.5 is a cap, it is not necessarily what we pay every month.

So obviously it could be more than that.

Those are value-based fees.

The reason why Kansas is lower right now, versus Kansas City is because we sense that our current arrangements that we had so those fees were higher for a period of time, they're lower now.

We are working on more value based arrangements and obviously if the claims -- if the claims don't go down, the payments to the providers to get them to do the quality of care don't happen.

On the smart shopper, that fee, I think it was the 32 to 27 percent reduction on that was the state doesn't pay us a per member per month fee, they pay us a percent of those shoppable services, I'm looking over here, getting a head nod so I know I'm correct.

Those shoppable services on that.

So it's only if they access it.

There is a cost and a quality component of that too.

So man, you don't want to go have eye surgery with the cheapest guy out there, I hear you on that.

So there's a cost and quality measure that is in there in that.
Sometimes -- a lot of times your lowest cost providers are your highest quality providers
as well because they don't have the episode issues that they have with that.
Anything else we need to clarify?
Looking at the team today, was there anything else?
You want to am come up?

>> Melissa brown is our avp of provider network.

>> I just want to address the question about the nurse practitioners and APRN's
being included, those are the instructions we were given when given the provider
counts.

That's why they are included.

>> Does that help answer.

>> It does, thank you very much.

>> Thank you for the time.

>> CHAIR PROFFITT: Thank you for the closing pitch.

should we do this like politics and provide equal airtime for the other vendor, probably
should.

Aetna, anything you'd like to -- I almost made the mistake it entered my head, I guess
making the mistake walking in saying I think we'll have a -- here we are.

But it's good information because we are making a three-year commitment here.

If you can introduce yourself for the group please.

>> I'm Darren brooden, Senior Vice President for Aetna.

Lead the labor public labor segment.

One of the things I'd like to say to the committee if the concern with, you know, going
with Aetna full replacement is the rural areas, I can promise you this afternoon
recruitment efforts would start in those rural areas with the communication that the state
has voted to fully Aetna.

That conversation with the providers would be a very different one with that information.
So.

>> Kendra black with Aetna.

I also would like to mention that our administrative fee did not increase from 2023, it did
remain the same and remains the same for the full three years.

Also, for the smart shopper, we actually have -- you know it as health care blue book,
it's now called VALENS.

The you're not going to go to them for a heart transplant.

They're going to be services that are commonly repeated, whether it's knee
replacement, shoulders, colonoscopy, all of the providers are in network, but they do
specific -- they may do 10, 15, you know, every couple of days so we want to make sure
we are keeping those services with where the majority is being completed.

So we don't have someone that's doing a knee transplant every six months, these are
people that are consistently doing it.

So that's where we are hoping our members would go to get those discounts.

>> Also I think the health plan allowance that was \$1 million, that says per year, just as blue indicated on theirs.

>> Thank you.

>> CHAIR PROFFITT: Thank you.

dare I ask any more questions?

>> I'm the President of the Employee advisory committee, I would propose that you ask to what extent the provider populations overlap with one another.

Because a provider might take both Blue Cross, blue shield and Aetna, and they're showing total numbers, but one provider may accept both.

So the change may not be substantial.

>> CHAIR PROFFITT: I would be shocked if we had that information off the top of our head here, a good question to keep in mind, it's probably not unique, not a or b.

>> I can't tell you off the top of my head, we do have disruptions so I can provide that information also.

>> CHAIR PROFFITT: Thank you.

Commissioner Dechant.

>> STEVE DECHANT: Jennifer, a question to you.

Kind of raised the local versus not local provider in terms of being in state Aetna versus Blue Cross Blue Shield.

Scrap what concerns, what issues around that or any kind of support or -- support or responsiveness do you as staff have with one or the other?

>> JENNIFER FLORY: I think from the staff perspective, when we contact the vendors for first, both of them are highly responsive to our member needs, when a member contacts us and they have a question and we need to go to them to follow up on their claim, we expect the response back from that vendor within three business days. So we get good response from both.

I would maybe suggest that if the commission is thinking that they want to go with one vendor and you have concerns about the network, you might want to think about do you want to put a specific performance guarantee in place regarding network enhancements?

>> STEVE DECHANT: Okay.

Well, Commissioner Schmidt, a question to you in your official capacity as insurance Commissioner, do you, or your office, similar kind of question, deal with probably complaints if it comes to your office, with issues of one provider over the other.

>> VICKI SCHMIDT: They're pretty responsive because we fine them if they're not.

So we seem to have good cooperation.

We have a different hammer.

But I think -- but I would just say the performance guarantees on the provider network, that didn't work out so well with us on the i contract.

I would just point that out.

>> CHAIR PROFFITT: Any follow ups.

>> STEVE DECHANT: No, thank you.

>> CHAIR PROFFITT: Commissioner Schmidt, did you have a question?

Did I see your hand up for another question before Commissioner Dechant?

all right.

Seeing no further discussion, the time has come, Commissioners, I would entertain a motion should somebody choose to make one on a decision for the ASO contracts.

Commissioner Schmidt.

>> VICKI SCHMIDT: Mr. Chairman, I don't want to make a motion, but I would like the other information on the provider networks and the question that the Employee Advisory Committee asked.

So I think that first thing we need some of the numbers updated.

>> CHAIR PROFFITT: I hate to ask, to suggest that you prefer not to make a decision, Sid that what you're saying?

>> VICKI SCHMIDT: I'd like to know the time sensitivity of it of making a decision today versus.

>> CHAIR PROFFITT: That's my next question to staff.

Director Flory, this impacts open enrollment during August.

are we -- excuse me.

>> VICKI SCHMIDT: October.

>> CHAIR PROFFITT: We like to have things by the August meeting.

>> JENNIFER FLORY: The June meeting, you have to make the decision by the June meeting, and the June meeting you already have a very full agenda.

You could do a phone meeting or something, if you wanted.

>> CHAIR PROFFITT: We could do it in person, given our experience with phone meetings, probably a special meeting we would call to find a time that works in May if we're going to go down that path.

>> BILL SUTTON: Thank you, Mr. Chair.

I am curious, it was mentioned about network adequacy provisions being -- what would that look like?

In an effort to maybe move things before the June meeting.

You know, what would that look like as far as performance measures or performance requirements are concerned?

>> CHAIR PROFFITT: Staff needs to answer that question.

>> JENNIFER FLORY: I think the concern is predominantly in the rural areas. So we could require that given that the start of the program year is 1/1/27, that there is an expectation that the number of providers in the regions that we highlight increase by x percent, 10 percent, 5 percent, would -- yeah, Paul is saying by October 1. October 1 helps for open enrollment purposes, but actually you could have -- you could even do it two tiered, 5 percent increase between now and October 1 and then another 5 percent before the start of the plan year, there's a variety of ways you could structure that.

Specifically probably we don't -- region 1 is very well represented. It would be a question on what other regions.

If you look on page 28 within your book, you can see that Gina has outlined how those -- how those networks are in each of the regions.

So like, for example, if you're looking at Aetna's best for ancillary providers in region 5, they have 74 percent, where Blue Cross Blue Shield has 97 percent.

That really shows you -- also in region 6, Aetna has 27.6 percent of the ancillary providers, again Gina identified those as being like your physical therapists and a variety of practitioners, where Blue Cross Blue Shield has 78 percent.

So when you look at -- also in region 2, ancillary providers, looks like in region 3 it's ancillary providers, that appears to be the area where, based on this chart, the need is probably the greatest to see an enhancement in that network.

If does that help?

>> BILL SUTTON: It does.

Would it be possible to put those performance measures based on the ancillary or other ancillary or other providers as specifically.

>> JENNIFER FLORY: Yes.

We would need Aetna here to agree that they would be willing to agree to some type of an enhancement in the network in those areas?

>> BILL SUTTON: Thank you, Mr. Chair, sorry.

I'm processing here.

I'm working on it here.

I'm a dollar and cent guy, we have the responsibility to our plan members.

When I'm looking at a \$55 million reduction to our plan members, I have a -- over three years, that is, I have a tough time running away from that.

I have to take that very seriously.

I would make the motion to move forward with the Aetna only local best with the network -- network adequacy performance measures that were just described, 5 percent on ancillary services by October 1, 10 percent by January 1.

>> CHAIR PROFFITT: Commission, you've heard the motion, is there a second?

>> STEVE DECHANT: For the sake of further discussion, second.

>> CHAIR PROFFITT: There's a second, Commissioner Dechant, further discussion?

>> STEVE DECHANT: I'm doing some quick math.

page 20.

three-year cost.

I'm not sure who to ask to respond, maybe Jennifer or Gina.

excuse me.

Aetna only has a 1.2 billion three-year cost, Blue Cross Blue Shield 1.5.

But doing the math a little closer, I think it's a difference of 238 million.

Over those three years, which would be about 70 million a year.

Is my math close to correct and if so, what other hidden, I'll call them -- what other costs are out there that are not potentially under that. I heard we number up to 3 million a year on admin costs I believe that were not included.

That's my question.

>> There's nothing that will disrupt this number from you.

There are more nonclaim fees flowing through the claim wire from Blue Cross Blue Shield than from Aetna at this time.

>> STEVE DECHANT: We are looking at 238, \$240 million over 3 years difference?

>> It could be a little bit more.

>> STEVE DECHANT: Or more.

Thank you.

Just a comment, I -- I certainly am leaning towards Aetna only.

My concern is areas 2, 3, 4 and 6.

One certainly, I don't think, will be negatively impacted if at all.

5, where I happen to live, probably not too much.

But I am concerned about those areas that are the most rural.

I think I'd like to flush out a little more in terms of -- get the word or the phrase, the expectation or coupled with the expectation the monetary, clawback, whatever may be associated with failure, by -- by Aetna if it was not bringing up substantially the providers in whatever one or several categories.

comments.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I think that the -- the monetary thing to me is secondary.

It is to you also.

The problem is, if it doesn't happen, then we have state employees without services.

And so the monetary is nice to -- as a stick, I guess, but I think the more important thing

is just having ancillary services for our employees and their families.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: I would like to follow up on what Commissioner Schmidt said as the representative for state employees, I just have concerns about the Aetna only plan because we have so many employees who are on Blue Cross Blue Shield and have used Blue Cross Blue Shield for all of time, and like they might have set providers. And there might not be another provider of that type in their community. I have a team of people who are based across the state, and I know that they already have problems accessing care and so I don't want to make it more difficult for state employees to access care.

Thank you.

>> CHAIR PROFFITT: Thank you, Commissioner Dechant.

>> STEVE DECHANT: Yes, thank you.

We used the term ancillary, page 28, and then page -- page -- no, back on 15.

I don't see that.

What falls into ancillary?

We have page 15 has hospitals, mental health, primary specialty, and mh.

What part of those fall into ancillary.

>> JENNIFER FLORY: On page 16, the second bullet point.

okay, diagnostic images, lab work, be physical therapy, custodial care.

>> STEVE DECHANT: Okay.

thank you.

but again, taking it back to 15, where does the numbers then?

The numbers of physical speech, occupational, custodial care, what column do they fall in on page 15?

They're not specialty physicians?

That's an assumption.

>> Some of the facilities may fall into -- I'm going to ask the vendors to clarify this instead of speaking out of turn here those categories.

>> CHAIR PROFFITT: Repeat that for the microphone for those only.

>> They are not sure the ancillary coverages are included in these categories that are in this access grid here.

>> STEVE DECHANT: How can that be the case and your comments at the bottom of page 16 set Blue Cross Blue Shielder notably higher.

You have to make met assessment.

>> It's in the claims that we have.

The so these discounts and these claims are in the detailed claims data that we have from the vendors.

But they may not have included those category in these particular categories when they completed the exhibit 8.

Network access by region.

>> CHAIR PROFFITT: The ancillary providers are not included, pt, ot, diagnostic lab are not included in the provider network on slide -- an exhibit a, they are included in the claims and penetration, separate on age 16.

>> Not included in the specialty or the.

>> CHAIR PROFFITT: While we are waiting.

>> I have to get back to you.

>> Melissa brown for Blue Cross Blue Shield.

I'd like to state when we were asked to complete exhibit a we were given specific instructions to include hospital providers, mental health providers, specialists, mental health providers who are professional instead of facility providers, and those were all included in exhibit 8.

The ancillary providers were not included as exhibit 8.

The they must have come from another exhibit included in the RFP response.

The pages are separated out differently.

Page 15 would include the providers specialty types that I just mentioned with very specific definitions behind them.

And then page 16 included the ancillary providers, I'm assuming either based on claims data or additional exhibits may have been provided at the time.

>> CHAIR PROFFITT: Thank you for the clarification.

Commissioner Schmidt?

>> VICKI SCHMIDT: Mr. Chairman, I would just say, we have to get better at writing these RFP's, because we are -- we are asking questions about ancillary services, which we have a total knee and have to drive two hours to get pt, that is not going to be acceptable to many of our -- I mean, that just doesn't -- can't happen for three or four weeks afterwards, we have got to get better at doing this.

I mean -- I know that three years ago we had this same discussion on the providers and how we were -- that we weren't comparing them together.

I could get my notes back out, probably nobody wants that.

I do have them, though.

>> CHAIR PROFFITT: I trust you.

>> VICKI SCHMIDT: What did you say.

>> CHAIR PROFFITT: I trust you.

>> VICKI SCHMIDT: Anyway.
I just think -- we have to get better at this on these RFP's.

>> CHAIR PROFFITT: Just for point of clarity, did we circulate this purchase to the commission before it was posted for review.

>> JENNIFER FLORY: We did.

>> CHAIR PROFFITT: We do get the opportunity to review the RFP.

Point well taken, I think maybe you're taking about the summary.

The staff does up that.

>> VICKI SCHMIDT: I understands I had that opportunity, Mr. Chairman, I appreciate that opportunity, but I also know we have a consultant that should be helping us with some of these questions because they do other plans, and these are not new issues to our plan.

>> CHAIR PROFFITT: Fair.

Any other discussion on the motion?

Director Flory.

>> JENNIFER FLORY: If the decision is to go with a performance guarantee, I think we need a dollar amount that goes with those percentages, and either from first would suggest maybe we ask our friends at Aetna to speak to that and make some ideas that the commission can then think about and make their own choice.

>> CHAIR PROFFITT: I think I prefer to have the commission set the dollar amount of the penalty as opposed to the vendor setting their own penalty amount.

Although reverse psychology, choose my own punishment didn't go well.

I appreciate the suggestion, commission, set our own penalty. I think Segal might be somebody better than the vendor.

Commissioner Sutton.

>> BILL SUTTON: Thank you, Mr. Chair.

I would object to Segal on that one.

I don't have any grasp of what a suitable penalty would be.

>> CHAIR PROFFITT: Any thoughts?

I know we are catching up.

>> It can be based on a percentage of increase, it can be based on -- in terms of the performance guarantee itself, it could be a number of facilities versus how many people are in that area.

But we can come up with a dollar amount penalty also.

To go along with that.

>> CHAIR PROFFITT: Commissioner Sutton.

>> BILL SUTTON: Thank you, Mr. Chair.

I would certainly want, as a percentage of the number of people in the region, I think that's absolutely necessary for our calculations there.

Thank you, Mr. Chair.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Just -- so I make sure I understands.

If a provider was not contracting with the provider that we choose, then the member could still see that -- see their other provider, they would be out of network and they would have their same things that we do on any other out of network?

>> Correct.

>> VICKI SCHMIDT: In that case, I would like to make I substitute motion.

I think I can make a substitute motion to table this until a future meeting when we have the information that we have requested.

, it's been eight years since I've been in the legislature.

>> CHAIR PROFFITT: A motion to table is in order.

Yeah.

I don't think it's debatable either.

have the Robert's book out?

without an objection, we will say it's not debatable.

Should have looked to my left.

Thank you, second on the motion to table.

All those in favor to table to a future meeting yet to be determined say "aye."

[chorus of ayes]

any opposed?

Motion carries.

This discussion is tabled and we will get our calendars out at the end of this meeting to determine a date between now and the June meeting to receive the follow up and have this discussion.

All right.

Moving on, to -- discussion items.

Doing that a lot.

We are going to review the financial report.

So if you want to come on up and introduce yourself.

Commissioners we'll move into tab 3 although I think the presentation might just be a quick presentation versus just the report.

>> We are going to shift a little bit to slides.

So the same information that you're used to in the memo, but in the slide format for ease of presentation.

Welcome feedback on that afterwards if y'all have thoughts, we thought this might be -- make the tables a little bit bigger, Melanie, consulting actuary with Segal.

Here are to talk you through the financial report this morning.

I had to check, it's not afternoon yet, still this morning.

And we have data through February, so we'll be discussing those first two months of

2026 and then the productions further out.

Next slide, we'll start with the year to date experience, so here we have the January through February 2026 experience, increases the reserve balance through February closed at 32.3 million verdicts the 36.4 million that was initially projected in the budget. If you look up at the individual lines, we are showing a slight increase on medical and a decrease on pharmacy.

Request this view is just a little misleading because the amount of -- the number of payments that we have in the budgeted column, there's a mismatch between the number of payments we budgeted for and the number that came through in the first two months of the year.

This view is a little bit misleading.

That did balance out in March.

When we neutralize for that impact, we see that medical claims are actually up about 3.7 percent over projections in pharmacy claims up about 9 1/2 percent over projections.

You will see that increase in experience reflected in the projections for the out years.

looking at the multi-year projection summary, the impact of is the merging experience is a \$17.9 million decrease to our projection for calendar year 26 with the new balance being projected at \$6.5 million.

The I was just going to address that piece, I did want to call your attention to a slight revision that was made as we were reviewing for the meeting, we found an inconsistent formula in the cell and wanted to provide the updated numbers here.

They are slightly different from what may be in your packet.

I can point out where those differences lie.

The they lie in the program revenue and then you will see some slight changes in net income and reserve balance.

This was a net positive impact to the plan and changes the funding -- the funding rate by about .2 percent.

You'll still see that the projections for 27 and 28 result in negative reserve balances, but there are -- the numbers have changed there just slightly as a result of that revision.

Looking at the funding rate, and we chatted about that a little bit, but the funding rate that's calculated is 8.6 percent versus the 8.8 percent that you had in the packet that was initially presented and that is what results in that slight decrease in the program revenue with the target still being achieved.

There in the calendar year 2030.

What was that.

>> Could you put that slide up you're talking about.

>> The funding rate.

The next one.

Yes.

this 8.6 percent, if we target that -- if we budget for the target in 2030 with the 8.6 funding rate, we do see a negative balance in both 27 and 28.

If we were to target a zero-dollar balance in 2027 the rate for the employee and

employer both would be 13.1 percent.

Those out years, this is calculated in a different model.

Not able to get this revision in this slide, but for those out years you see 6.3 percent with the revision, those would be 5.4 percent. I apologize we weren't able to get that into this slide update.

Those are calculated separately.

We did have a request from the Commissioner also of what would be the necessary employer increase if we were to hold the employee increase constant in 2027.

And that number remains at 17.9 and for those out years the 27 through 2030, the increase would be 4.3 percent for those out years.

The sensitivity analysis shows the impact of plus or minus 1 percent in the trend.

On our projections.

If you look at 2030, you can see the breadth of the impact of that assumption with a pause of 1 percent resulting in a negative \$22 million balance in 2030 and a 1 percent -- 1 percent better resulting in \$168.8 million balance, and looking into 2027, all of these scenarios currently show negative balances for 27 within that range on the trend.

The other rate shows -- the other table shows the impact of a million dollars to the funding rate.

So this shows how sensitive the funding rate is to that million dollars.

With I know secretary last time you asked if that was linear, we did look at that this time, we have the \$17.9 million decrease in the calendar year 26 reserve balance, and these numbers are rounded off here, if you use nonrounded numbers, you land at the percent difference we are seeing from the 7 percent we presented last name.

The math there does roughly translate.

Questions?

>> CHAIR PROFFITT: Thank you.

Questions?

Commissioner Schmidt?

>> VICKI SCHMIDT: So I'm a little disappointed.

I mean I marked up a lot of questions in the financials and then to hear that, well, they don't really mean anything because we found the thing in the cells that are wrong.

I'm going to proceed with my questions.

We don't have this information, why not?

>> Certainly.

I would be glad to answer questions and again I do apologize, this is something we obviously never want to happen.

As I said, as I was reviewing for the presentation, we found one cell that had an inconsistent formula that did affect the numbers.

We want to provide you with the best information, so we chose to go ahead and update these slides so that you would have that information.

The impact to the story overall remains the same and the reason this wasn't caught in

the checks was because the outcome that it produced was within a reasonable range. It's well within the range of possibilities, but we wanted to make sure that you had the correct information.

Understand that it's difficult not to be able to review it ahead of time.

I imagine many of your questions will likely still be applicable where.

Again, in that multi-year projection, none of the expenses, like none of the expense lines changed, it's just the reserve -- sorry, just the revenue line, the net income and then that reserve balance.

If you have questions regarding the specific expense lines, none of those changed.

It was.

>> VICKI SCHMIDT: Go back to your slide about where you're looking January through February.

The.

>> Those should not have changed.

>> VICKI SCHMIDT: Tell me what -- I'm sorry, I don't have very good eyes anymore.

The what is the rx claims, 28.8 or 28.6?

Well, my -- okay.

The thing I want to ask about is how did we go from 6.6 to 21.9 from January to February?

The shortest month of the year and we went to 21 --

>> Sorry, where is the 6.6?

>> VICKI SCHMIDT: It is January actual.

February actual is 21.9.

>> Oh, sorry.

Yes.

>> VICKI SCHMIDT: It's good to put that in combined because you would never notice that.

I don't want it combined, I want month by month.

>> We do provide both of those pieces. The reason being it comes down to the invoice timing p and I don't know if we have that.

It's in the memo.

She's talking about the calendar year 26 variance, the calendar year, it's in the model, but the -- the difference is because of the invoice timing, so when we budget, we budget based off of how many invoices we expect to receive in the month.

For pharmacy, generally that's two a month, and for medical it depends on how many weeks there are in the month.

And so basically what happened was there was a mismatch in the payments.

So we only had one pharmacy payment in January, we have -- then you may have three in February, be so that's why there's that swing and that's why I was saying even looking at them combined, looking at January through February combined is somewhat misleading.

You look at the January through February combined, we were budgeting for one more medical invoice than was actually paid.

So one medical invoice, you know, was supposed to be paid at the very end of the month and gets pushed through to March, and so when you look at what we budgeted for, we were budgeting for one more invoice than what actually came through.

It says you have a gain of that \$2.4 million, but that's assuming that we are looking apples to apples and you paid the number of invoices we budgeted for.

Which is not what occurred.

That's why I was saying even looking at the two months composite, because of those payment timing differences, can sometimes be a little tricky, just based off of when those checks get run.

>> VICKI SCHMIDT: Why wouldn't our vendors be sending those invoices on time?

>> I don't have the direct answer to why those payments.

>> CHAIR PROFFITT: Jennifer.

>> JENNIFER FLORY: It can depend.

We generally get two pharmacy bills a month, but we got one in January, and if I remember correctly, we get the bill and then we get detail and there was a discrepancy between the dollars on the bill and the invoice detail and so we went back to the vendor and asked for clarifications, and there was conversations back and forth and until we were satisfied that the numbers matched, we didn't pay it.

So that pushed it into February.

So what typically would have been paid in January, it ultimately gets paid in February because we were working with the vendor to make sure that the numbers were accurate.

>> VICKI SCHMIDT: I appreciate that, but I don't think -- I mean, is that the first time that's happened with CVS Caremark.

>> JENNIFER FLORY: It's a first time in a long time it's happened.

It happens with all vendors at some point where we get information that doesn't necessarily line up with what we expect and could be because if the claim totals like, for example on the medical side are much higher than what we expect, we may go back and ask a lot more questions about were there a lot of high cost claims, higher claim volume.

We'll ask questions until we are satisfied we understands what is happening with that invoice.

It can happen with any of them.

The with this one, it particularly was pharmacy that we had questions and we did not pay it until our questions were answered to our satisfaction.

>> VICKI SCHMIDT: I guess my question would be, why wasn't that explanation included in this?

>> So I did not include the full length of that explanation.

There is some language regarding the payment timing in the memo which is referencing this payment time if the commission would like more detailed information regarding that payment timing, it does get very weedy, but if you would appreciate more detail

regarding the payment timing to be provided in the future, we would be happy to do that.

>> VICKI SCHMIDT: It's shocking, I spent a lot of time on these numbers wondering what happened between 6.6 million and 21.9 million in January and February.

I mean, I have a lot of theories on that now, none of which were true.

>> Sure, sure.

I can appreciate that.

We are happy to provide a little more detail there as well.

Those exhibits come out of the model and so we would probably have to provide like a supplementary exhibit to potentially explain any of those, you know large variances

you might see and wonder about in the model where they're not part of the memo.

We could do that in the future.

>> VICKI SCHMIDT: Lastly, the error you found in the cell calculation, has it been wrong for years or?

>> It has not.

It was just this one model is just -- one spot there was an inconsistent formula in one cell.

Like I said, we see the same pattern with the fix, we see the same pattern that you still have those negative balances in 27 and 28.

It had a .2 percent impact on that funding rate.

But we wanted implement that fix and make sure that you had the best information here today.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: Do we know what drove the \$8 million overage in prescription costs?

>> Again, some of that is a payment timing issue, you're going to see -- if you look at the detailed month by month that Commissioner Schmidt was referencing, if you look into March, we are expecting march to be low.

So that does balance it out.

To again it's payment timing issue where we had more payments made in February and then in March, you'll have lower payments that will offset that and so that is really what's driving the bulk of that.

But, gone, even when we correct for that, even when we do look across what we expect for March, including the first full quarter to kind of balance out that payment timing, even when we look at that, pharmacy is running about 9 1/2 percent over what we originally projected.

It is.

>> STEVE DECHANT: My question, do we know what's driving that?

>> Question, when I spoke with Caremark, they are seeing increases in utilization, it's a little difficult -- we only have hard data through -- I only have hard data

through February, it takes time to get the third month in, which makes pharmacy tricky because of 90-day fills.

It's hard to do like a look at why that trend is really up in that short period of time, but based on discussions with Caremark, they have indicated they are seeing increases in utilization that's driving the cost increase.

>> STEVE DECHANT: We don't know what areas of utilization?

>> I don't know specifically at this point.

>> STEVE DECHANT: And so the model is projecting that, I think 9.7 percent will continue through the course of the year.

And therefore the negative balances that are being projected for out years 27 and 28.

>> It wouldn't be -- the model wouldn't be assuming they full 9 1/2 percent through the rest of the year.

What the model would do, look at the last 12 months.

So essentially what happened is when we add in this new experience, it drops off the old experience and so it really impacts the projection is the difference between, you know, the part that we dropped off and the part that we added.

We did make an uniform. To the projections so we weren't overprojecting with data through February, we made an adjustment to the fact that we are expecting the March payments to be lower, to make sure we didn't overinflate numbers due to that payment timing issue, but the addition of that experience was high enough that it did have material impact on the projections going forward, although, again, it's medical and pharmacy both contributing to those increases.

So unfortunately, we are seeing adverse experience on both lines.

>> CHAIR PROFFITT: Any follow ups.

>> STEVE DECHANT: No, thank you.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I'm not sure that I follow what you said or I guess I don't agree with what you said because the initial budget for rx claims was 10.6 million in January, 9.3 in February, and 9.5.

That comes to 29 -- approximately 29.5 million.

But when I add up 21.9, which is almost 22 plus 6.6, plus 4.7, it's far more.

The budget is far more than the -- that's not even with all the March claims in.

So we are not -- you're not close on the pharmacy.

So what is cause -- is that the GLP-1?

>> I didn't -- yeah, we are seeing that it's not close, the farm says running much higher than budget even with the adjustments.

And, again, it does look like we do have reports, that was my first question, are we seeing increases, is the aom, the bm I-35 on the apartment obesity medications high costs.

We are seeing reductions on that.

It looks to be utilization broadly.

Like I said, when we get more data and we have some data on 90-day fills and things

like that, we can make some better -- do better analysis to determine exactly where that's driving.

As of now we know it's driven mostly by utilization.

>> VICKI SCHMIDT: The GLP-1s are not even in the 90-day supply?

>> No, we looked at those to make sure, that's not what we are seeing, we are not seeing that as the driver.

>> VICKI SCHMIDT: Well, a different question, I guess, but I would like a clarification on where we are -- where we are on the GLP-1s because I left the meeting last time unclear as to what the prior authorization is.

Because the -- the intent of the commission, when we discussed this, was one thing, we were not going to grandfather, I don't think there's my -- I don't think there's my disagreement about that, we were not going to grandfather.

And so the issue was when you hit 35, on your bmi, we were not paying for the medication, but Caremark did not -- CVS Caremark did not institute that, and I kind of like to know how they think they can overrule what the commission says, and why are. And we still haven't changed it, I don't think.

But I don't know for sure.

Do you know?

>> We -- to my knowledge, and I would ask Caremark to please clarify, to I my knowledge, it is running as was discussed to the last meeting. I do know.

>> VICKI SCHMIDT: What is that?

>> It's the bmi of -- Brian, do you want to --

>> CHAIR PROFFITT: If we can keep the remarks brief, I know we have to have the discussion.

>> CVS Caremark, Travis.

>> Yeah, Travis Tate with CVS Caremark, I oversee the formularies.

>> VICKI SCHMIDT: Either one pharmacists.

>> Correct.

So the current setup replays the bm I-35 plus the continuation of therapy, which is what we discussed last time.

>> The current setup replays the same implemented 1/125626 with a continuation of therapy and bm I-35.

>> VICKI SCHMIDT: That is not what this commission directed you to do.

>> I know we discussed this, a few months ago, but that's the current setup that we have in place.

>> VICKI SCHMIDT: Well, you know, I don't understand why we are even sitting in these chairs if CVS Caremark will decide the policy on GLP-1s.

Because we decide the policy, you implement.

So -- we had this discussion last time but left with no action item on it.

You know, why would you -- why would you want to go against what the commission has decided.

>> CHAIR PROFFITT: I'll interject.

I want to make sure we stay on topic.

We had this topic last time.

I understand the answers may not have been satisfactory, I believe we did, through absent action of the commission, discuss making sure we tightened up the language with the next plan design discussion to happen in June.

Therefore, I don't think that we anticipated my changes in CVS Caremark, don't disagree, we had this decision time, stick though the agenda.

>> VICKI SCHMIDT: I would respectfully disagree that we didn't take a vote on it.

We did not -- we -- if you did it by consent, I don't know about that.

Because I would not have consented to that.

The so when we start telling our employees that we're going to have 13 percent increase after they get a 1 percent raise from the state, a 13 percent increase in their health care insurance to make the bottom line meet because GLP-1s have consumed millions -- 20 million over \$20 million in our plan and we sat here and didn't do anything about it, I don't want to take those calls and if I do, I'll be expressing -- I do not think that we came to a consensus last time.

We left here with the discussion with no item -- with no action taken, and I don't think that was right because I don't think that CVS should drive the train on GLP-1s.

And I would -- I would always make my motion to discontinue the contract with CVS because of things like this.

And the settlement.

Anyway, I'll be quiet.

If you want to say we're not going to do anything about it this entire plan year, we will be sucking air by the end of this time.

>> CHAIR PROFFITT: Thank you.

The any other questions on the report before we move to a every brief discussion of plan decision, initial discussion.

>> JENNIFER FLORY: We want teat to bring up the spreadsheet, Pete, can you please bring up the spreadsheet.

so we just wanted to open the discussion today, this is not for decision today, this will be at the June meeting.

Can you go to the -- plan change summary.

So as part of the decision that you all will be making at the June meeting, in addition to deciding on the premium, be you may decide you also wish to, instead of doing whatever it would take to get the premium, you are wanting to get to make plan design changes.

Just threw together some options for you all to think about, to consider.

We are looking for ideas on what you might want to see.

The so I want to run through the model just so you can understand what the model does.

so for example, in the model, we have put in a number of different changes that potentially could reduce the amount of premium increase you might need to consider. So just to run the model for example, let's do a yes on line 20.

>> CHAIR PROFFITT: Think we are --
>> You went over it.

>> JENNIFER FLORY: On the model we have put in change options for you like increasing the deductible, increases the coinsurance. In your packet in the back, in the follow up items, we did show you how many people today meet the deductible by plan so that you can understand that if you make a change in the deductible on Plan A, you can see the cost savings there if you were to increase it 250 or 500 for a family.

That's a cost savings of 1.8 million. That's because currently over 10,000 single members in Plan A meet the deductible. Conversely when you go down to like Plan C, you'll see the savings by increasing it the same amount only results in \$978,000 savings.

That's because very few of our Plan C and plan m members actually meet their deductibles.

We also showed you some options if you would want to increase the coinsurance, let's go back up to Plan A, there were a couple of different ones up there.

The on Plan A today, we have a diabetic and asthma program where generic drugs have a 10 percent coinsurance up to a cap of ten dollars.

On brand name drugs for diabetes and asthma, we have a 20 percent coinsurance to a cap of \$20.

If you were to remove those caps, you can see the savings is a million dollars.

So we were just trying to give you some things to think about, there are copays on Plan A that you could increase, you could increase the cost for telehealth.

You could increase the coinsurance on -- special case tier, that's really old benefit that you may want to consider eliminating.

Special case and special t are not the same thing.

Special case is a list of -- these are old high-cost drugs.

Back when we went to coinsurance in the year 2000, we put in the special case so that if the drug was really expensive with a coinsurance and our members had been used to copays, we could put it on this list and cap how much the employee paid for it.

The list is really old, it's down to about one page, it's not widely utilized, resulting in why the savings if you eliminated that is only \$101,000.

So it would simplify our plan if we eliminated that benefit.

Then if you move to Plan C, we show you what increases the deductible, increasing the coinsurance as many of our Plan C and n members don't get out of it deductible phase, increasing the coinsurance or out of pocket don't result in a lot of big savings.

We threw out some options. Further down, scroll up a little, Pete, Plan J enrollment is only 585 contracts, so making a change here is not going to save much money.

Then we threw in GLP-1 options to consider, terminate -- if you wanted to terminate all aom coverage, we are working with Segal to figure out if there's a cost impact of savings there.

If we went to adding a \$200 copay, it would actually cost the plan 1.1 million. The if we decided to use the baseline GLP-1 35 or higher and eliminate 5 percent continuous reduction that we have been talking about, that would cost the plan \$13.5 million because there's a loss of rebates associated with that. We also looked at what if we went to a 35 bmi and we required the member to lose 5 percent at each PA. The so every time they'd have to go 5 percent lower, that actually cost us even more, that cost us 22 million. That wasn't a great idea. We are were looking for you all, if you have ideas on something you would like us to put on here for -- to potentially save money, we could show it on here. On the next slide, then, the assumption page, here's where we are going to put in potential premium increases for both the employer and employee and we can run the model with whatever you choose. With but we just wanted you to get familiar, this is what you'll be doing at the June meeting. In your books, this year, for this meeting, I actually included -- one of our open enrollment books, Commissioner Schmidt, I can give you this one, I wanted to refresh your memories of what the plan designs look like today and I didn't know if y'all had an actual physical copy, I did put that in your packet. With that, ask unless there are questions, I am good.

>> CHAIR PROFFITT: Thank you.

So again, commission, we have been doing this for a couple of years, we should be familiar with this, we have ideas not later than May 8 to give the consultants time to run this through the model and see what the impacts will be for any decision we make at the June meeting.

The request would be not to have any walk-aunts at the June meeting.

so May 8 is the drop dead to get information, you can just send any request to Director Flory and she will make sure that gets over to the consultants. It was mentioned previously there was a request to see what the employer contribution would need to increase in plan year 27 if we held employees flat.

Full disclosure, that request came from me, the same concerns about employee, executive branch employees, 1 percent pay increase, not nearly enough for the work that they do.

Somebody making \$40,000 a year, that's a \$400 increase once the state gets money back and feds, that's \$275 on the year.

So to increase employee contributions after about \$275 cash for the year is going to eat into that negate any pay increase.

I would also note they we have done a really good job over the last 6, 7, 8 years of trying to mitigate any employee contribution increases.

I don't want anybody to lose sight of the fact that there's a three-year time frame during -- between 15 and 18, 14 and 17, be three years in a row, 30 percent increase, 18 percent increase.

So we are just now restabilizing and getting employees back to where the trend line

should have been but for the double digit increases tacked on top of each other.
With that, I am going to be pushing for as minimal of an increase for employees as humanly possible to offset the lack of a pay increase.
Commissioner Schmidt?

>> VICKI SCHMIDT: I just want to point out that these bottom line numbers don't include the ASO.
This will be updated depending on what the decision is made about the ASO, correct?

>> CHAIR PROFFITT: Staff?

>> As long as that decision is made, yeah, we need to take that into account when we discuss the meeting timing to ensure that we have proper time to implement that so you do have that information.

>> CHAIR PROFFITT: Was going to talk about dates at the end of the next meeting. Because I said May 8, my target week would be to have the meeting May 4, May 5, 6, 7 or 8.

>> VICKI SCHMIDT: And then just the last question on the ones about the changes in the plan design, so I have requested that we see what that is per member, per month, cap I see it?

No.
It's on there, I didn't -- we didn't go over far enough.

that's okay, okay.
Thank you.

>> CHAIR PROFFITT: To set that up, that's a good request by the Commissioner, we see total dollar, Commissioner Schmidt wanted to see what that means for an employee.

Slide out to the right, you'll be able to see that.
I believe we'll -- will we get a live version of the spreadsheet or is that my request.

>> JENNIFER FLORY: Typically.

>> CHAIR PROFFITT: Cat's out of it bag.

>> VICKI SCHMIDT: Special treatment up there.

>> CHAIR PROFFITT: Okay.

Commissioner Dechant, did you have a.

>> STEVE DECHANT: Can we get a copy of that, just to know at least.

>> CHAIR PROFFITT: If we can get a no links file.

with no macros in it to make it easier to send.

>> Yes, if you're wanting to Tinker, macros are necessary, but if you just want to see what the savings are, we can provide that without macros.

>> CHAIR PROFFITT: Send a dead version immediately following this meeting so we can see the layout, that would be helpful.

>> STEVE DECHANT: To have an idea what kind of increases or decreases based on the action.

Vice-president.

>> If we send a dead version, you won't -- it won't show you what the impact is to the funding rate, but you would of the savings numbers.

>> STEVE DECHANT: What we saw here this morning.

>> VICKI SCHMIDT: Can we not say dead.

>> Sorry.

>> CHAIR PROFFITT: My fault.

Commissioner Hensley.

>> ANTHONY HENSLEY: Remind me, what was the Governor's recommendation on the state employee pay?

>> CHAIR PROFFITT: 2 1/2 percent, sir.

>> ANTHONY HENSLEY: The legislature passed 1 percent.

>> CHAIR PROFFITT: Yes, sir.

>> ANTHONY HENSLEY: What did they do for themselves?

>> CHAIR PROFFITT: This discussion happened last week, like to say away from that. More than 2 1/2 percent.

>> ANTHONY HENSLEY: I think it was 4.4.

Yeah.

thank you.

>> VICKI SCHMIDT: It's 4.4 percent.

>> CHAIR PROFFITT: 4.4 percent.

I.

>> VICKI SCHMIDT: Just what it is.

>> CHAIR PROFFITT: All right.

Seeing nothing else, the next bullet is adjusting, it says June 2, but we all know that's not going to happen.

It will happen, we'll have another one prior to then.

I would like to target the week of May 4 for the next week, I'm out of it state on May 4.

Looking at calendars would.

>> VICKI SCHMIDT: I'm out that week at the conference.

>> CHAIR PROFFITT: The prior week any good?

>> ANTHONY HENSLEY: You're talking about April -- what did is that the.

>> CHAIR PROFFITT: The week of the 27th.
I would be available.

>> I would be available.

I'm sorry.
Out on Monday the 27th.
28th on a would be available.

>> CHAIR PROFFITT: The 29th or 30th.
>> VICKI SCHMIDT: I'm are not available that week.

>> CHAIR PROFFITT: Okay.
I don't even know what today is, tax day.

how quickly can we have the information from -- well, counters the week of May 15.
I understands that's one week past -- the week of May 11 rather -- shoot.

what if we did May 11.
If that work for anybody.
>> I could do that.

>> CHAIR PROFFITT: Yes, Commissioner Sutton.
Commit Schmidt.

>> VICKI SCHMIDT: Can do May 11.
>> CHAIR PROFFITT: We'll push the drop dead do May 11 instead of May 8.
Not later than date.

So the earlier you can get your request for information in, the better.
But we won't have the ASO information until may 11 so let's give plan request designs
for ideas.
Not later than May 8.
Plan for a commission meeting on May 11. Why I think on a Monday, typically
afternoon works better, is that correct, Jen -- commission have a preference, morning or
afternoon, morning it is.
All right.

why don't we plan for 9:30.
Commissioner Dechant, that work for you.
>> STEVE DECHANT: I can make it work.

>> CHAIR PROFFITT: Jennifer, if you can mark that down, all information and follow
ups from them ASO, any follow-ups asked of Segal, we need to make sure we have
that.
If we can get information out to the commission well in advance, once you bet that,
review that thoroughly and provide any questions you might have during the meeting in
advance to Jennifer and she'll get that to the vendors so they can be prepared to

answer those questions, that work?

okay.

On our next meeting, we'll still hold the June 2 date for plan design and a few other RFP decisions to make during that time.

Commissioner, I point your attention to the appendices a, b and c, in tab 4.

Tab 4 or the appendix, I'm not going to run through those, certainly if somebody has a question on some of them, happy to give you an opportunity to ask that.

Not seeing any.

All righty.

The I would entertain a motion adjourn, unless I'm missing something.

>> So moved.

>> CHAIR PROFFITT: Do we have a second.

Second, Commissioner Cain.

All in favor, say "aye,"

[chorus of ayes]

Any opposed.

We are adjourned.