

ROUGHLY EDITED TRANSCRIPT  
KANSAS SEHP MEETING  
MAY 11, 2026  
9:30 A.M.

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>> CHAIR PROFFITT: Ready to go?

we're good?

All right, good morning, I'm going to call this morning to order, 9:31 on May 11.

Thank you very much for making it to this special meeting of the health care commission.

I know there was some conversation we had last week that we wanted to pick back up Todd and will do that in due time.

Before we get moving, I do want to make sure that I thank Director and the entire of the staff again. I always appreciate them being able to share their board room with us and making sure we are well taken care of up here at the table.

With that we'll take roll.

>> CRISTI CAIN: Here.

>> STEVE DECHANT: Here

CHAIR PROFFITT: Gossage indicated she would be would not be here.

>> ANTHONY HENSLEY: Can you hear me?

>> CHAIR PROFFITT: we can barely hear you.

Try that again, please.

Commissioner Hensley, try that again, please.

We might try that later.

We'll count that as a yes.

Need to be careful when I do that.

>> BILL SUTTON: here.

>> VICKI SCHMIDT: Here.

CHAIR PROFFITT: Approval of minutes, should have had a chance to review, any additions to the minutes.

Hearing none, I would welcome a motion to approve.

>> So moved.

>> CHAIR PROFFITT: All in favor, say "aye."

[ chorus of ayes ]

any opposed?

Okay.

Motion passes, minutes are approved.

All right.

next order of business, we are going to be discussing the administrative sources organization's commonly known as the vendor contract we started discussing at our last meeting.

There was some information circulated to the committee on tab 2, I believe.

Additionally, there was some questions that were submitted in advance, I appreciate the commission's willingness to do that.

We got answers back from Siegel late on Friday.

they were distributed just this morning electronically, we have paper copies here, I think we'll start with Siegel, giving a presentation, on the follow-up items from the RFP evaluation and it's in tab 2.

Introduce yourself for those that are watching online, please.

>> Good morning.

I'm Janice sander with Segal.

And we're going to go over the additional information that was requested in the 4/15 meeting.

So let's go to slide No. 11.

In the April presentation, we are just going to recap here a little bit.

We received bids from Aetna and Blue Cross Blue Shield of Kansas, and the -- regarding the network access.

There were questionable variations in primary care, mental health and substance use disorder provider counts and specialists.

The network utilization, excuse me, was based on eligible claim dollars, and you had a good number of claims flowing through your network so you have good in network utilization, in the 90s.

But we did notice when we looked at place of service specific information, that the ancillary charges were a little bit low in Aetna's network.

The network discount differentials, we had some variation between the differentials there, and we'll come back with additional information about those.

Next slide.

here's the financial summary.

For year one, showing savings here.

You can see that the net effective discount line, there were variances ranging from 3.9 to 6 percentage points difference.

Aetna was also offering their local best network, which is basically the same network you have now, the cpos2 and in the five counties listed here, Johnson, Wyandotte, Jackson, Platte, cass and clay, they have higher inpatient and outpatient discounts.

next slide.

so this was the three-year recap estimate, and there were some questions about the \$221 million savings for moving to the local best, and that's what we were going back to get some additional information about and the network access disruptions.

next slide.

we had some follow up items.

On the network access, we were going to more closely align the Aetna and Blue Cross Blue Shield provider categorizations, and we did get more information from Aetna, more detail from them, and I would say we have apples to apples, might be red delicious to granny Smith, but they just categorize things differently, and I -- there was a handout that went out this morning because there was a question about whether they were on the same basis, and one of the examples I gave was that one might say endocrinology as a whole, the other one might break the down and say endocrinology,

metabolism and diabetes, endocrinology, reproduction.

So it's endocrinology, but some break it down further.

we analyzed the disruptions, and we'll have some of that information coming up.

We outlined the discount guarantee offers, and we looked at the additional fees that were in the claim wire, Commissioner Schmidt, I know you had asked about that and we provided some information.

Earlier, and I think it's in the back of this packet also.

We'll move to the next slide.

So the last time we were here, I believe, Aetna had not included some of their nurse practitioners and pa's and they went back and broke down in detail more the numbers and included the numbers that were outlined in the RFP.

For the various providers included in the PCP category.

And that PCP category -- the PCP category includes general practice, family practice medicine, geriatrics and physician extenders.

which are the PAs and the nurse practitioners.

you had a question about the ob/gyn's, they were not in the defined list of the -- that were in the RFP.

the primary care physicians are still quite far apart in numbers.

The specialty physicians are still quite far apart in numbers.

In total when you combine those, they are very close, and the mental health providers are significantly higher showing in Aetna.

There are still some gaps, but this exhibit doesn't really tell you how many people are -- what kind of access in terms of how far they drive.

It does tell you how many people -- how many providers are in each county.

But it doesn't necessarily tell you how far they drive to see a provider.

I think they both have good numbers of providers.

Let's go to the next slide.

So we compared the numbers here again, and Aetna's total provider count for the categories listed is about 13,627 higher, and primarily of course in the specialty and mh category.

so we put a heat map over here to the left side with the colors.

And overall, Aetna has one PCP for every ten covered lives enrolled in the SEHP medical plan.

On a county level, when we looked at the individual counties, the largest ratio spreads were in Stanton and Hamilton counties with 1 in 40 and 1 in 38 respectively.

On the next page, page 17, so here -- there's really very little disruptions in the number of claims, and the allowed claim dollars.

The primary disrupted services were air ambulance and mental health substance use disorder facilities.

And several of those were out of state.

Looking at Aetna local best versus the current Blue Cross Blue Shield Aetna blend, there were about 5 percent claims disrupted, and 3 percent of the allowed claim dollars disrupted.

And looking at the will low best versus Blue Cross Blue Shield network in total, there were about 6 percent of disrupted claims and 3 percent of allowed disrupted.

>> I'm Kirsten from Segal.

I wanted to make a point here.

When we were looking back at the other slide at the number of providers, we are not getting apples to apples. What we wanted to look at is disruptions.

What disruptions is, we put out one -- 1 months worth of claims actually the claims that were paid in

2025.

And when we have them do the repricing, we also had them say is this in or out of network, numbers apples and oranges and can't get to the information there, we say, if Aetna was -- if everybody moved Aetna, how many would be disrupted.

That's what we were looking at here, how many claims would be disrupted, what's the allowed amount that would be disrupted. So that gives us more information on would people be moving physicians and providers or not.

So just wanted to make clear why we go from -- from the numbers looking at before to look at disruptions.

Does that make sense?

>> CHAIR PROFFITT: Commissioner Schmidt.

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

I notice on the sentence before that, you talk about the primary disrupted services include air ambulance and mental health substance use disorder treatments and facilities, several out of state.

Of that 5 percent and 3 percent, how many of those are out of state?

>> So we may have that number.

What we are trying to say here, if we look at it and we have 5 percent of claims disrupted, 3 percent of allowed amount disrupted, we go back and look, what are the disruptions and mostly what we see are air ambulance, which may or may not be in network thing, I think a lot of that goes through -- yeah, the independent resolution type claims, and then the mental health substance use disorder treatment facilities with several out of state.

So that's also just another category.

So the majority of that 3 percent, that is disrupted are in those categories.

Does that make sense?

>> VICKI SCHMIDT: I just wanted a specific percentage, but just the majority like 90 percent of it, 95 percent.

>> Probably.

I mean we looked more for primary care.

There was one physician that came up that was toward the top.

I mean, it's a lot of ones and 2's and small dollars, there was one that came up and it was a mental health provider, so we really didn't see, like, primary care or specialty care in that category.

>> VICKI SCHMIDT: Another follow up.

So those were all claims, whether they were emergency room or otherwise because these would be -- these are in network and out of network?

>> These are the claims that were -- that were in network with Blue Cross Blue Shield that were shown out of network at Aetna.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Please continue.

>> Okay.

To your question, Commissioner Schmidt, a large majority of those, I would say, probably 75 percent or so, were the air ambulance and the mental health treatment facilities or mental health providers.

You asked about out of the state, there were 5 that were in the top, say, 25 there, that were out of state.

All right.

Let's move on to slide 18.

Both Aetna and Blue Cross Blue Shield offered network guarantees by place of service, so when they offer these guarantees, it's by inpatient, outpatient and professional categorization, based on place of service.

And Aetna gave us an illustrative overall network discount also of 63.1, and Blue Cross Blue Shield did not give us an overall illustrative figure.

The so we calculated it based on the composite and proportion of the inpatient/outpatient and

professional dollars.

So Aetna's composite discount was 63.1 percent.

And they have 50 percent of their admin fee at risk.

So should Aetna fail to meet the guaranteed discount, the penalty would be paid out at the rate of 2 percent for each full 1 percent the guaranteed discount is missed.

The and ASO fees are not that large compared to your claims that you have.

So Blue Cross Blue Shield's composite discount rate is 59.5 percent.

And they have 3 percent of admin fees at risk and should they fail to meet the guaranteed discount, the penalty is paid in full immediately.

They have no requirement that it be below the discount.

It's pass or fail.

To illustrate the impact, we assumed a discount came in at 59.4, which is just below Blue Cross Blue Shield's composite illustrative composite rate.

So Blue Cross Blue Shield would immediately pay 100 percent of the 3 percent of admin fees, which would be about \$470,000.

And Aetna would pay 2 percent for every full 1 percent, between the 61.3 and the 59.4, so where so that's 6 percent essentially, which is \$713,000.

The next Page, 19, Aetna also offer -- next page, 19, Aetna offered a trend guarantee. It assumes if you keep the same blend that you have now and they continue with about 4500 plan enrollees, the trend guaranteed discount is 5.1 percent.

With 50 percent of the admin fees at risk.

If they are full replacement, then they're guaranteed a trend of .9 percent with 75 percent of admin fees at risk.

So if they fail to meet the guarantee, it has the same type of cadence with 2 percent of the admin fee paid for each full 1 percent the trend guarantee is missed.

And you have the option of choosing one or the other.

The discount guarantee or the trend guarantee.

So similar to the calculation of the discount guarantee, if they missed a trend guarantee by 3 percent, the payout would be \$713,000.

We'll go to the next section.

So these figures that I just went over were based on the bafo's from each one.

Each vendor that submitted a charge.

The so we asked some additional information after the bafo.

I had asked Blue Cross Blue Shield.

One of the questions I asked them was if they could improve their penalty and tell me how the penalty would be paid out.

If they missed a discount guarantee.

And they actually submitted a whole brand new discount guarantee.

Which is significantly higher than what they were showing in their original and in their bafo.

so their composite, again, we had to calculate this, but it matches what Aetna had provided.

63.1 percent and they upped their admin fees at risk to 5 percent, so if they should fail to meet the 63.1 percent, assume it comes in at 63 percent, it's pass/fail again, based on 5 percent of admin fees, the penalty payment would be 782,000.

And at this point, if Aetna -- if Aetna was also -- had a guarantee and it came in at the 63, they would not pay yet because that's not a full 1 percent below the guarantee.

They wouldn't pay until it hit 62.1.

That would be 2 percent of the ASO fee at risk, which would be 238,000.

The

slide 22.

So slide 22, we also received revised blue card fees from Blue Cross Blue Shield.

They had told us earlier in the process they were expecting these fees to be reduced, and so when they received confirmation, they submitted those.

So the fee percentage for the plus card is reducing -- blue card is 1.66 percent to 1.61 percent.

For claims processed in other blue organizations.

Are there any questions at this time?

>> CHAIR PROFFITT: Why don't we hold on questions, Pete, I don't know if you're able to pull up the supplemental document circulated this morning.

We can go from the hard copy and voiceover.

Just hit the highlights.

Don't read the whole thing, highlights of the questions and general answer and from there, I think we can go to questions.

>> Okay.

All right.

So Commissioner Sutton had asked how the numbers would look if you went with Aetna only or Blue Cross Blue Shield only.

And so we did -- we put that in the model, briefly, kind of back of the neck and didn't have time to fully build out the model.

We would expect the 8.6 percent that we had in the financials before for 2027 to drop by approximately 4 percent to 4.6 percent.

So that's the 8 percent -- 8.6 percent, we were calculating to hit the target on balance in 2030.

That would drop about 4 percent.

>> CHAIR PROFFITT: Keep on going through all these questions until the end, please.

>> Okay.

So there was a question about the hospitals.

Hospitals that are independent to each bid be listed, so we went through and looked at the data, this was all based on your actual utilizations, these were providers that your members have used during 2025.

And there are two hospitals, rock regional and a new health that were in Blue Cross Blue Shield but considered out of network with Aetna, and we know rock regional actually has closed in January.

So one hospital with a new health.

Outside of Kansas, there appear to be 16 hospitals in the Blue Cross Blue Shield network but not in the Aetna network.

And the disruptions of these, these aren't used super frequently, so the numbers are very small, and outside Kansas, there were also six hospitals that are not currently in the Blue Cross Blue Shield network but would be in the local Aetna first network.

Including prime health services in Kansas City.

Question two, are the providers discounts that are included and materials guaranteed for full three-year contract and yes, they are.

The necessary's guarantee is flat for three years, they have the same discount guarantee for all three years, Blue Cross Blue Shield's increases by .2 percentage points per year from their bafo and their unsolicited increases also by an amount.

I don't have the provider discounts for Aetna and Blue Cross Blue Shield varied over the past years.

So we looked back over the last three procurement cycles, and I know you have this in your folder.

So we looked at the baseline from each of the vendors that had come in each of those procurement periods, and what they had REN priced.

The baseline for Aetna and for 2020 what I explained, these 2020, looking back, looking at data from the year prior.

So 2019, 2020 is 2019, 23 is 22.

26 is 25, and then the re priced claims are projected for the year ahead.

23 is 24 and 26 is 27.

So the baseline for Aetna has gradually increased from 62 in 2020 to 63.9 in 2026.

This is for cpos2.

The re priced claims when they -- when we say re priced, that was based on the overall, that was a combined of Blue Cross Blue Shield and Aetna's discounts.

Repricing is based on the full amount, not just their proportion, in 2020 it was watered down what with the 55.5 percent and then 23, they had improved their contracts and it was up to 62.73.

64.9 in 26.

Of course, the local best was only included in this procurement cycle, and it's showing 67.

for Blue Cross Blue Shield, the baseline moved from 56.9 in 2020 to 62.5 in 2026 with repriced claims running 56.9 in 2020 to 61 in 2026.

so those have shown improvement.

>> I'll make at point here.

Just so you understand the process.

We can, on baseline, we can calculate that.

When we send out a file and ask them to reprice, it's self reported, but when they bring it in and it's based on their contracts that they have in place.

We clarify, you've repriced all these claims, we say here's the discount us as of the repricing date.

Do you have any known improvements that would change this, do you have any assumed increases in eligible charges that would change this?

You have any other anticipated contract improvements.

We make them walk this down when we are looking at it to make sure that we are getting the best information we can, not just here, we repriced it.

Wanted to give that clarification as to the detail we go through with them to make sure we are getting a good number here.

>> All right.

There was a question about whether ob/gyn's were included in either of the PCP counts.

They are not, that was not one of the specialties that was in the defining list in the RFP.

So you had asked about the data here.

So we requested clarifications from the vendors several times, and I know last time we were waiting, we had gone back to Blue Cross Blue Shield twice and four times Aetna.

At the last meeting we were still waiting for Aetna to respond to our 4th request for additional information.

So that's why it was not in that meeting information.

And we did receive it just a couple of days after.

The so that is all in the information that's provided in this -- the new grids that show from exhibit 8 in the earlier slides.

You had asked about whether it was apples to apples, all on the same basis, again, they just break it down differently.

All vendors categorize a little bit differently.

so we looked back at the 2023 Blue Cross Blue Shield PCP count, which was around 8700, and in 26 they're now reporting 18,000.

So it's -- it seems unlikely that they would have added 10,000 PCP since 2023, but rather than depending solely on what they had, we pulled it from these files that we have of your actual experience for 2025 and who was using which providers.

The so these providers that we have listed here in this document -- so in the State of Kansas and Missouri, there are 238 PCPs that are in the Blue Cross Blue Shield network.

Those show as disrupted, which means your people are using the Blue Cross Blue Shield providers, they probably are enrolled in the Blue Cross Blue Shield plan and that's why they would have to move to these other providers.

The these PCPs represent approximately 2500 claims, 1700 claimants and \$740,000.

A lot of these are just one or two claims.

So if we dropped the number, if we said okay, let's look at 90 percent of the dollars, of those dollars disrupted, it drops the number of PCPs disrupted to 80.

If we said let's look at 80 percent of those dollars disrupted, it dropped it to 45.

Looking at 70 percent of those dollars, disrupted, dropped to it 4.

You can see it decreases rapidly as you look at kind of a scale of where disruptions might occur.

So 75 percent of the disrupted PCPs fall into Sedgwick, Johnson, Jackson, Wyandotte and Shawnee Counties.

So the largest disruptions we saw was in Sedgwick county, it was 70 PCPs, all the way down to Shawnee County, which was 10 PCPs.

So those top five dropping from 70 to 10, there's just not a whole lot of disruptions.

And, again, this D.C. eruption says -- disruptions is based on the providers you utilize.

It may not show those that are totally available to them.

Outside of Kansas and Missouri, there are 184 PCPs that are in Blue Cross Blue Shield but nature in Aetna.

They represent approximately 460 claims, and only \$65,000.

So positive disruptions in the State of Kansas and Missouri, there are 51 PCPs that are not currently in the Blue Cross Blue Shield network, but would be in the Aetna local first network.

And so we do feel that Aetna has adequate numbers of providers.

But this is all based on your utilization, so if you moved, we might want to look at how many more are available to them in the network in that area.

>> CHAIR PROFFITT: Thank you for running through that.

Appreciate that.

Before we move to comments and questions, just one note, staff if we could put more descriptive header on this and make sure we post this with meeting materials since we weren't able to have it online.

So they have full opportunity to see this.

>> Will do.

>> CHAIR PROFFITT: Thank you.

Commissioners, any questions about either the presentation that was online or the comments.

questions or comments?

>> VICKI SCHMIDT: I want to go back to the additional unsolicited information.

>> What are you going back to.

>> VICKI SCHMIDT: The additional unsolicited information.

What I heard you say was you went back to Blue Cross Blue Shield and asked them to see if they could tune up their numbers?

>> I asked only for the penalty.

Can you improve the penalty payout and tell me how you would pay out the penalty.

>> VICKI SCHMIDT: Why did we say that's unsolicited because you solicited it?

>> That was for the bafo.

Pre-bofo, they had -- bafo, they have guarantees that were half percent and improved them to 3 percent.

unsolicited we got different guarantees with 5 percent.

After this meeting last time.

>> VICKI SCHMIDT: What we saw in our notebook, a couple of weeks ago, was not the best and final offer?

>> What you saw in the notebook last meeting was the best and final offer.

Which was when she had gone back and asked them to improve.

>> VICKI SCHMIDT: After that meeting?

>> No, prior to the meeting.

The so let me go back and make this super clear.

First -- at first they submitted guarantees with a half percent of admin fees at risk.

During discussions and back and forth and clarifications, before the bafo, Gina asked them if they could improve that.

In the bafo, they submitted the same guarantees with 3 percent of admin fees at risk.

After the last meeting, they then sent in this unsolicited guarantee, which increased the discounts that they were guaranteed and the amount at risk to 5 percent.

>> VICKI SCHMIDT: Was Aetna given the same opportunity to give unsolicited information?

>> They were not.

And because it was received, we asked for legal advice on this, and they asked us to put it in the materials as unsolicited.

>> VICKI SCHMIDT: I guess I am a little -- I'm not understanding, why I guess, because when we were doing the pbm contract, I asked Segal to go back and talk to the vendors and to see if there were certain things, I won't go into it here, but somebody could listen to that boring meeting I guess, and I was told under no circumstances could we ever accept anything after the bafo.

>> I agree, that's why we -- in my opinion, in our opinion, that was post- bafo, because it came to us unsolicited and we asked the -- the plan went back to the attorney to ask if they wanted it in here or not.

He asked us to put it in here marked as unsolicited, so I agree with you, it is not part of the procurement, but we did as the -- as legal told us to, put it in here and mark it unsolicited.

>> VICKI SCHMIDT: What did your legal say about that?

>> It wasn't our legal.

It was plan's legal.

>> VICKI SCHMIDT: Well, I guess I only have a problem because I've asked for it to be done before, and our legal said we absolutely could not do it.

Now we can.

And I don't understand that.

>> CHAIR PROFFITT: If I may.

Elongate this.

I think the differentiation here, our legal would say we aren't going back after the meeting and request information.

The information was received unsolicited and because the information was received unsolicited, our legal counsel said, present it, make sure it is Crystal clear it was with unsolicited information, the commission has no obligation to act on this information, but I think that's the line of demarcation, there was no requested for additional information after the meeting after the bafo and in this instance simply received.

I want to make sure you understand the order of operations.

Jordan, correct me if I got that wrong.

>> VICKI SCHMIDT: From my perspective, are then, we would not look very smart if we would go with Blue Cross Blue Shield and not take that unsolicited information into account.

Now you've put us in a situation where we now have unicorns information that -- I mean -- unsolicited information, I've never heard of that in the eight years I've been on this committee being presented.

I have some other questions, though, if one is appropriate.

>> CHAIR PROFFITT: Go ahead.

>> VICKI SCHMIDT: I was kind of disappointed to receive the -- this memo 8:25 this morning, you know, I know most of these are my questions, and it's a lot to digest when I got 20 minutes to drive over here and it's 8:30 in the morning and -- I mean, I think that's not very -- if you receive this -- if you -- why was the submission so late?

We had this meeting and we asked these questions last week.

Why was it so late to get us the information?

>> It's a tremendous amount of information, we had our data teams go back and had to work on it for us to pull the information out and it takes a lot of time to get to it.

We are looking for -- through an entire year of claims, and they had to do their work before we could even receive the information.

So Gina and I were up late Friday night getting this out.

It's just the best we could do, it's a lot of data.

>> VICKI SCHMIDT: When did you receive these questions?

>> I believe it was Wednesday.

>> VICKI SCHMIDT: I'm sorry Wednesday?

So I would have thought maybe spend Wednesday and Thursday night getting it ready and then we could have had it on Friday.

>> The data team was working Wednesday and Thursday on it to get us the information.

>> VICKI SCHMIDT: All right.

I have some questions about the responses.

I think that, number one, the question No. 1 was can the hospitals that are independent to each bid be listed, and I don't see a listing.

I just see numbers.

I asked for them to be listed.

So I want to know, the six hospitals not currently in Blue Cross Blue Shield but are in Aetna local, I want to know the 16 hospitals, where are they at?

I want to know the two hospitals, one is closed, you did give me -- new health.

Do you not under the question doesn't do any good at 10 after 10:00. "Now I have no time to look at the list.

>> Well, I mean all of those were out of state.

The so services happen when they're out of state.

They may be in.

>> VICKI SCHMIDT: Any of those emergency situations because they would have been in network because they were emergency situations, was that taken into account?

>> We have claim line detail, we don't know that.

>> VICKI SCHMIDT: Well, who does?

>> If we get a claim that has a -- you know, if it's an E.R. claim or inpatient claim, we have procedure codes, but we are basically dealing with -- the data that is behind this, Gina and I can't look at, we don't program in SQL.

We have so much data programming to pull this out.

We are going back and forth, pull us this and that and looking at that.

I mean, I think once we got to the point where we saw the number of hospitals and the hospitals we said okay, there are some in multiple states that don't have anything to do with what's happening in this state.

We look to see none of those were even in Missouri, so they weren't around the Kansas City area, and the two that we pulled were -- had claims of less than -- what was it?

\$185,000.

>> I can used to that rock is closed and Paul looked up a new health is actually a skilled nursing facility in Holton, Kansas.

Will

>> VICKI SCHMIDT: Why is it included in the hospital?

>> It is a facility and so it's included as a facility.

>> CHAIR PROFFITT: Can you speak into the microphone.

>> The code that was associated with that facility submitted to us was a hospital code.

It was not nursing facility code.

There are facilities with nursing facility codes, but the code that came across with that one was hospital.

>> VICKI SCHMIDT: I guess, you know, I continue to say this and I -- we pay over \$40,000 a month to you, and it's very frustrating.

If you couldn't -- if you didn't want to list all these, you should have said we aren't going to list the independent hospitals like you asked, we'll give you the summary information.

It's insulting to me I asked for the list and you don't provide it.

Anyway, on.

>> CHAIR PROFFITT: We have other Commissioners.

Commission Sutton.

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

I was just going to chime in a little bit earlier in the line of questioning there.

I think part of that, the delay on this was my fault.

I kind of slow played one of my questions, so I really didn't expect to have an answer, I was kind of impressed that you had one even this morning, not a lot of time to look at it in advance, I get that.

But I was impressed that I had an answer at all.

So that was -- I did appreciate that. I just wanted to chime in on that part of it.

I get the part about not having a lot of time to review, but I'll have to claim a little bit of guilt on that one.

Thank you, Mr. Chair.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: Thank you.

On page 12, slide 12, the financial summary first-year costs.

Do those costs reflected there include the follow up information, the administrative cost rebates, not including the additional unsolicited.

Does that spring all of that information to bear here, and I must admit I didn't compare this with last meeting's sheet to see how or if they were different.

Do we have a full and complete rendition of all costs?

>> These are the same ones that were shown in the last meeting.

The only thing that changed -- the only thing that changed from last meeting was I was trying to get more clarification on the difference between the providers and where they were bucketed, which is why we went back and said we are still a little different on things and we took some other steps to try to do some comparisons.

So the first thing we did was go back to the disruptions to say, to say how many of these claims that are in the current incumbent, incumbent meaning any claims that came from Blue Cross Blue Shield or any claims that came from Aetna or Aetna claims, rather than the full list of services and providers that were provided in calendar year 25, how many were marked out of network for Aetna.

So that was the main thing.

There are no differences in any of the financials from what we had last meeting.

We did do some on -- which page?

We did some calculations on the penalty payouts, if they were to hit those, and, you know, with honestly, even though we have new guarantees, unicorns unsolicited.

>> STEVE DECHANT: Couple of hundred dollars different.

>> If we missed that, it's such a small piece of it, that we are showing it, but none of the financials have changed.

>> STEVE DECHANT: Essentially the financials have not changed.

>> We were trying to do more analysis on provider disruptions.

>> STEVE DECHANT: Can you give my qualitative comparison, disruptions-wise or -- and/or -- and physician-wise.

I know you talked about the ratio and mentioned two particular rural counties in Western Kansas where it jumped up to 1 to 40 and 1 to 38.

Taking out the 5 big counties, Sedgwick Johnson, Jackson and Missouri, Wyandotte in Shawnee, compared to everything -- the rest of the state, what kind of impact is happening outside of the -- I'll call metropolitan areas -- I'll call it metropolitan areas in terms of access to PCPs, which seem to be the difference.

Can you give me some qualitative on that.

You talked about 90 percent of the dollars dropped, all represented to the big counties, versus the rural.

Portion of our state.

>> I mean we kind of did it across the board.

I'm from a small town and we tonight have many PCPs in our town.

We know that we're going to drive at least 45 minutes to a PCP or to a specialist for sure, probably 100-mile if we are going for something serious, PCPs, I don't know -- I don't know if the Department of Insurance has a metric here that you look at.

The

the other states that I work in, I'm looking at a metric of do you have at least one per 30.

So here, we don't have full population, but at least we tried on the one slide, let's go back two slides.

16, please.

so when we did covered lives per PCP, that was our attempt to say we don't have apples to apples, the number of PCPs Aetna is showing there and look at it per covered lives per PCP, what numbers are we getting?

And most of the time, you can see along the regions, you know, it's way below 1 to 30 and we just kind of called out these Stanton and Hamilton because they were above 30, which seems to be the baseline that's in -- that I've seen in other places. Yes, there's some variation because there's variation in the number of PCPs in any rural county, and we have a full listing of that too.

I think -- we called out Stanton and Hamilton because they stood out to us.

I mean, if we came in here with all of the analysis that has gone behind it, you couldn't put it on slides.

It's just tremendous.

>> CHAIR PROFFITT: Commissioner Dechant, follow ups.

>> STEVE DECHANT: I'm done for now, thank you.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I am confused on page 3 of the stuff that we received today.

So the provider numbers just don't make sense.

In 2023 to 2026 Blue Cross Blue Shield is reporting 18,000 plus PCPs.

>> In this one, they're reporting 18,000.

>> VICKI SCHMIDT: Does that make sense?

>> That's kind of our comment there.

So we have been focused on does Aetna have enough PCPs because they're so much lower.

Can we go back one slide, please, Pete.

So if we look at the number of primary care physicians, we have been focused on the fact that Aetna has only 7,099 compared to 18,188 in Blue Cross Blue Shield.

But when we go back to the listservtation, that was three years -- solicitation from three years ago and we had the same information from Blue Cross Blue Shield, it was around 8700.

So it just feels unlikely that there have been 9 to 10,000 PCPs added in the state from three years ago.

So, you know, they have systems they're pulling, self-reported.

The we keep going back and getting more clarification and more clarification, but at the end of the day, we tonight have access to their system so we are just looking back to see, does this make sense.

>> VICKI SCHMIDT: Okay.

I have a procedure question.

Or how things proceeded in the past.

So when an RFP -- when we go out on the street for an RFP, well, first of all, I was kind of struck, I did pull the information from three years ago, and it kind of struck me that the -- several of the pages are just the same, three years and nothing changed in the RFP and nothing -- there wasn't any -- I would think in three years time some of the analysis could have been different, some of the -- some of the things would change, but they're exactly the same, but I guess more importantly, to me, when I look at these bids, if I received a made for anything, just home repair or whatever, and there was that much difference in what one company submit ted versus the other company, it's -- it's a lot of money over a three-year period of time.

The so when that happens, and do your -- Division of Budget, I think, the procurement office, where's that at?

>> CHAIR PROFFITT: The procurement out of sits in the Department of Administration, budget completely separate.

It's not run through necessarily the regular procurement process, are State Employee Health Plan has a different process.

The Department of Administration does assist and helps work through the process.

It's in the State Employee Health Plan that does have that.

We have the attorneys from the procurement assist.

>> VICKI SCHMIDT: So it's a State Employee Health Plan, it's our employees that -- State Employee Health Plan that look at the bids.

>> CHAIR PROFFITT: With the assistance of Segal, obviously, they're the ones that have all the data scientists and actuaries.

With many of the bids, you get into actuaries debating with each other what meanings of the coding is.

Segal does a lot of the heavy lifting as our consultant there with their actuaries and data scientists.

Our team does a lot of the communication to include our attorneys that help with the procurement.

>> VICKI SCHMIDT: Having two lawyers in a room.

>> CHAIR PROFFITT: It's actually -- well, I won't.

>> VICKI SCHMIDT: All right, all right.

Well, I guess I would just -- like before we got to bafo, never even knew that word before eight years ago.

Before we got to bafo, did we -- did we reach back out and say, my goodness, there's such -- we want to make sure we have all the information about what you're including and what the other -- I mean, at least when -- when we were looking at an RFP in our office lately, we went back to the companies and said there's a big difference here, we want to make sure we are understanding it.

Did we go back and ask that.

>> CHAIR PROFFITT: I'll let Director Flory jump in one second.

The follow up sheet that came out this morning, there is a note in there, they went back two times and four times just on the provider type.

There was a clear back and forth there.

Back and forth.

Discussion back and forth, open discussion period with the bidders, whoever they might be to get further clarification and/or better pricing. I think that's standard, but yes that does happen.

As it relates to the \$200 million number that keeps being referenced, it's because Aetna has a tiered pricing structure.

At the tier they are at now the admin fee is x.

The more contracts is x, it goes to z and y and a.

Director Flory, if you want to correct anything I've said.

>> JENNIFER FLORY: That's exactly right.

We put out the definition of primary care provider is consistent with what you will find in Plan A, because that is the definition we use for the copay in Plan A.

So that was included with the information we presented to the vendors, and as Gina has mentioned, we have gone back and forth with the vendors multiple times regarding definitions of providers, and trying to get everybody on the same basis, but this isn't really different than any prior procurement that we have done, we always find that the vendors we ended up with their networks being a pineapple, a watermelon and it's very difficult to compare them because they are using, some of them break them down further, going based upon the information they have in their system which may not be consistent with how we are requesting it.

But we do through a lot of back and forth with the vendors, we do have attorneys present with us as part of that process.

>> VICKI SCHMIDT: Maybe my question wasn't -- I didn't phrase any question right.

While I appreciate the information about the providers, and I can't understand why we go back four times and don't get an answer and we tonight just say, like, this is the last time we're going to ask and you tell us or we're not -- we're done negotiating with you, I don't know. Four times to go back to somebody, even twice would to go back to somebody when you're doing this.

The what I'm trying to understand is when you receive the offers of the financial offers, do we go back and say -- not provider numbers, that's a whole different thing, just on the financials alone, these bids are real far apart.

>> May I?

>> CHAIR PROFFITT: Please.

>> So yes, and we did, and that's kind of what I was talking about.

>> JENNIFER FLORY: So I've been working exclusively with state health governments and I am an actuary for the past 20 years, I worked with many different states, we do RFP's all the time.

>> For some smaller groups, nonstates, procurements are done a different way.

This is best in class for a state level bid.

We don't rely -- there's information that is compiled between all of the carriers and the big consulting firms called a uniform dataset that is done through Millman, that we have access to that, we have -- everybody has access to that.

You will see some bids done on that.

What that is, is book of business, where they will go in by area and put in based on their book of business what the discounts are.

There are a few things that are wrong with that why we don't use it for states.

The one is, is based on a different membership, two is based on different providers.

What we do -- and the third thing is it's old.

So what we have right now is based on 2022 data, we are living in a world today where we have machine readable files out there that is from some of the transparency legislation that has come along.

The so they -- 22 is old.

We don't want to know what's happening in 2022.

That's why we go through the process to pull claim line detail for the entire 12 months.

It has all the information on there that they need for repricing.

Now, after that, it's self-reported.

Give us the allowed costs for every single claim.

It is self-reported.

Will that's why we get the first bids in, and we look at what's your run rate been, does it make sense to what you just repriced.

The if it doesn't, we go back for clarifications, then we go back, what I was talking about earlier, to say here's where you started, tell us anything else we need to know.

Any letters of intent coming, are they included in here?

Do you have any known contract improvements or decrements.

Sometimes a carrier is in negotiation with a hospital, and the hospital gets the best of them, that's going to be put in there. Why we go through all of these different things, when we look at discounts, a discount is based off of an eligible charge.

What's happening to the charge, right?

If the discount stays the same in the charge goes up, the allowed amount is different.

So we are going through all of these pieces to really try to get to is this a correct number?

Because it is self reported.

We asked them to do it.

We ask them to give us the allowed amount on a claim line detailed line and go back through all of these pieces to make sure that we are -- we're trying to compare apples to apples.

So there is a lot of clarification, and we do the clarification first mean, even when things don't line up on the provider side, we are doing clarification so we can bring this information to you.

But yes, we go as hard as we can, I would say this is best in class process.

Okay.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I went back and I'm not sure that my math is exactly right, but I'm pretty sure I'm in the ballpark.

You know, from 23 years ago, Aetna's bid went up about 30 percent but Blue Cross Blue Shield went up about 45 percent.

So that's a lot of -- that's a significant increase and we're talking billions of dollars.

>> The way I see it is three years ago, Aetna was ahead of Blue Cross Blue Shield by about -- they were showing about \$10 million a year difference.

Now, and that was in the pos2, now they're showing about 50 million, but then you add on the local best, it's another 25.

That's a lot of money, so even if you don't believe the 50, you got 10 you were showing before, Gina showed what we have seen over the past three years.

I think last time, Aetna came in with a discount that we walked it down through the process, talked about very much didn't -- wasn't sure we believed, but their run rate is showing it right now.

Now, caveat on that, their run rate is a very small population, right?

They have a very small piece of the pie here compared to Blue Cross Blue Shield.

So, you know, a run rate is only based on what we are showing today.

But -- yeah.

But, you know, when we did -- when we roll through with the numbers we have, the model, and said we believe it will drop, the increase to 4 percent over time, you know, you have two options, if you wanted to go with Aetna, the discount guarantees, a trend guarantee, the trend guarantee, if they keep just a piece of the pie, is, what, 5.1?

And if they got the whole thing, .9, close to the 4 percent we calculated, and we didn't look at that to calculate.

I actually kind of clarified that this morning.

Yeah, that was the difference in their discount.

So, you know, we are doing as much as we can to actually get to the numbers.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Couple more comments.

One last one on this.

The guarantees, the penalties they would pay, so to speak, the guarantees, those are all great, but behind every one of those there's a person who didn't get -- didn't get services or was in the middle of treatment and had to change and, you know, there's a lot -- there's a lot to think about when we think about this.

I guess I'm a little disappointed that -- again, you know, my assessment of the situation is somewhat different than maybe some.

I think we should have gone back and said, look, you know, these are wildly different, and is the best you can do.

Who was fighting for the State Employee Health Plan in these negotiations?

Not fighting, you understand what I mean, who was advocating for a better deal because, you know, if we're going to -- you know, I mean, I don't even know that -- I mean, it looks like the difference is about \$12,500 per state employee on the blended program.

You know, who is going to big that up, is the state going to pick that up, is the -- is the employee going to pick that up.

I mean, I don't think we can saddle our employees with that kind -- with that kind of an increase, and I don't -- I don't know that taxpayers think that they should take that kind of an increase in this -- in their taxes for State Employee Health Plan.

The I mean, you know, when honestly, with I think we have failed the state employees in this negotiation.

Thank you.

>> CHAIR PROFFITT: Just one comment on that.

I don't believe we are looking at \$200 million increase here.

I think it is, under the hypothetical situation Aetna has proposed, it would decrease.

We are not asking for an additional \$200 million.

3 percent annual increase, maybe Blue Cross Blue Shield, whatever that blended rate was.

It understand, you know, \$200 million difference, it's based on hypothetical as was just described and the whole -- the necessary could statewide network by the end of the calendar year which by their own admission they would have to get to work on that afternoon.

I would echo your comment, guarantees are a great incentive as a regulator to put against a vendor.

We need to have those in every single contract, full stop.

We do that.

To your point, there is a disrupted life unless the money goes back to the individual, it means nothing to them.

And we can talk about a couple of points of disruptions being minimal, easy to say unless you're the one being disrupted, then it's a very big deal.

I liken to unemployment rate and 5 percent unemployment rate being historically low. Why unless you're in the 5 percent, it's a very big deal.

Just not looking for a discussion of that, but point that out as well.

>> VICKI SCHMIDT: I think part of the problem, though, is our reserves have decreased dramatically, and I think we have to address that maybe in a different way, I would be happy to talk about that whenever we want, but, you know, so that large number does come into play when we start talking about reserves.

>> CHAIR PROFFITT: I don't want to cut us off.

Do you want to move into procedural next steps.

If everybody is okay with that.

Make sure there aren't any follow-up questions.

Are.

>> STEVE DECHANT: Yes, thank you.

I want to bounce back to an issue Commissioner Cain raised last meeting, feedback and response, unsolicited response or feedback from members of -- who are on the health care plan, you talked about a survey, not saying there should or shouldn't have been, joke but what have we heard or what do we know in that regards, I don't know if that would go to you or someone else.

Have we got some feedback.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: I've gotten significant feedback, there were a couple of articles in the Kansas Lecter and one of them listed me as the contact person to let them know if they had issues.

I actually compiled a of the concerns state blows on had if now is okay if I share.

Okay.

And I heard from retirees too, Commissioner Dechant.

So they took time to share thoughtful feedback, personal experiences and in many cases real concerns about how this decision could impact their health care and their families and so I'm just going to provide a brief summary of some of the themes I heard as well as some direct quotes and stories from employees.

And so one thing that was pointed out is an overwhelming number of employees choose Blue Cross Blue Shield, 34,500 to 4,500 for Aetna, which means about 90 percent of employees choose Blue Cross Blue Shield when given the option.

As one employee put it, 90 percent of employees cannot be wrong in our opinion and voices should be counted, respected and valued.

And there were a lot of comments about this decision eliminating choice.

Moving to a single carrier removes meaningful choice for over 40,000 state pleas and their families, as one employee stated plainly, one option is not an option.

it takes at least two things to create an option.

Another echoed one option is not fair.

Another stated having only one vendor is no longer a choice, it's a Monopoly.

Choice is not just a preference, it's a protection.

If one plan denies coverage or lacks providers, employees can select another.

It ensures that different needs can be met across a diverse work force. I received many comments about the continuity of care and a lot of concerns about that.

So employees have spent years building trusted relationships with providers and specialists and disrupting that care is not a minor inconvenience, it can impact outcomes.

So one employee shared for over a decade I've built trusted relationships with providers who know my medical history, being forced to change plans would likely require me to change doctors, specialists and facilities, disrupting continuity of care and creating unnecessary risks, stress and expense.

One employee, Monica, shared that her family relies on Blue Cross Blue Shield for two medically complex children.

I received permission to share her story.

They regularly travel out of state for specialized care and recently flew to Baltimore for surgery.

The Blue Cross Blue Shield case managers have helped coordinate critical supplies and care preventing extended hospital stays.

She stated clearly if the choice were between losing Blue Cross Blue Shield or paying higher premiums, we would choose to pay more without hesitation.

And this was -- I heard from a number of people who either had serious conditions themselves or had children with ongoing medical needs and heard from employees with disabled children, chronic conditions or they have multiple specialists, and one parent shared, it took us seven years to get established care, the thought of having to adjust all this stuff

we lost Blue Cross Blue Shield is scary to me.

And another expressed urgency and fear for the love of everything holy, please don't.

As a single parent who provides insurance for myself and children, this would be very detrimental.

And I have two stories come in late yesterday that I really think make this point Crystal clear, one is from KU and one from k state.

And they both gave permission to share.

So one has been with ku for over 38 years and had Blue Cross Blue Shield the entire time, in the past five years she survived breast cancer and dealt with several other health concerns that she continues to seek care for.

There are no words for how stressful and concerning it would be to have to change my insurance after all this time.

I see multiple doctors and can't even imagine being forced to change over my insurance while trying to stay on top of my health.

I realize on paper that such a change does save significant money, but that should not be the priority here.

This could have serious consequences for hundreds, perhaps even thousands of Kansas residents.

It is not unreasonable to consider that it could significantly endanger many whose health care

coverage would be disrupted or even become unavailable.

Can we please put Kansas citizens and their health before the dollars.

And then now from two former ksu faculty.

I started working at k state in 1985 and his wife started in 1979.

The for all this time we have enjoyed the health benefits and good service of Blue Cross Blue Shield.

It is alarming to say the least we might be forced to switch Aetna with the needs we now have.

Both of us have cancer stories we can tell, and with my wife's metastatic breast cancer she needs treatments every 21 days at ku med in overland park, currently billed at \$80,000 each and scan services, et cetera, at other ku med clinics in Kansas City.

The combination of the disease and radiation treatments cause seven pelvic fractures which require extensive and ongoing physical therapy.

Which, fortunately, can be done in Manhattan.

Two rounds of throat and neck cancer, also treated at ku med, contemplating such a disruptive and potentially devastating loss of our current health benefits is emotionally distressing.

We have enough anxiety and frustration in our lives already.

We worked long and hard for 40 years for Kansas, believing in the land grant mission of the university that commitment and effort despite low pay and minimal pay raises when they did occur.

Understandably, we valued and do value our health benefits as a major component of our compensation and critical to our continued well-being.

Are and many employees brought up the limited or no Aetna access in rural areas and even in some urban areas.

One stated we live in a small town and a lot of places around here will not accept Aetna, and one, I kind of -- I'm curious now about, after seeing the information about the hospitals, this employee works remotely and lives in Lawrence, and said that Lawrence Memorial hospital does not accept Aetna.

Not sure if that's accurate, but according to this employee, it's a concern of hers.

So she said she would no longer have coverage in her hometown, she's a historical cancer patient and she routinely sees an oncologist.

So this change in coverage would force her to move away from the oncologist who has followed her

for several years post treatment, which would have a negative impact on her health.

Then another asked does Aetna provide coverage to all Kansas hospitals and other clinical settings?

No.

Root and there were a lot of comments about customer service and trust.

Employees consistently described Blue Cross Blue Shield as accessible and reliable.

People feel safe with Blue Cross Blue Shield from a member standpoint.

They have great customer service.

Am that was according to one employee.

And then in contrast, employees reported difficulty with Aetna, trouble finding provider lists, difficulty reaching customer service and lack of clear answers.

A team of employees shared their concerns together, so this is aggregated, but there is a general distrust of Aetna and their practices, and they provided citations to back that up.

With and then while Aetna may look good on paper, the inner practices of organization is troublesome.

Specifically Aetna denies pretty much everything at first, using various tactics, there were citations provided for that, as well.

This obviously causes a lot of stress and can be life threatening to employees with complex medical issues.

The employees have stated when they were on Aetna, medically essential treatments were denied and employees had to fight for emergency department and hospital admissions to be covered.

Blue Cross Blue Shield of Kansas is Kansas based, they employ Kansans across the state and invest in local communities.

Aetna is headquartered in Connecticut, and one employee said this decision is also about supporting Kansas jobs and keeping dollars in Kansas.

employees are not convinced that the promised savings are real or sustainable.

One employee captured this, Aetna saying that they will increase their network is like a car dealer saying I'll make sure this car runs after you buy it.

Another said ask to see their work on the calculations, which we did see a little while ago.

These are already having financial issues, one said the recent 1 percent raise does not come close to matching the realities of today's economy, and another pleaded, please, please, please do not move forward with any plans to drop Blue Cross Blue Shield.

This is one more hardship we do not need to be saddled with.

And that leads into several of the comments I had regarding recruitment and retention of state employees. Health insurance is one of the few remaining competitive advantages of state employment.

Before I accepted this job and relocated to Kansas for it, I asked questions about insurance coverage.

Having Blue Cross Blue Shield was one of my deciding factors.

Without this quality health insurance option, it will be harder to recruit and retain employees.

And one employee said I will be forced to reevaluate my employment options based on my health care needs.

Another stated our insurance benefits are one of the few things that actually make working for the state so attractive.

One retiree shared I believe that maintaining Blue Cross Blue Shield is highly beneficial for current State of Kansas employees.

The stability and broad network access they provide, urban and rural, are essential for employee retention and overall well being.

A plan that operates this smoothly allows employees to focus on their work, rather than navigating insurance hurdles.

And lots of employees echoed that this is more than about cost.

It's about value and trust.

Multiple employees feel this decision prioritizes cost over people.

One said this proposal is less focused on the well-being of employees and more centered on cutting costs.

Another emotional reaction highlights the urgency, news cannot happen, I'm freaking out.

many said that they've relied on Blue Cross Blue Shield for decades.

One said I've been on Blue Cross Blue Shield the 28 years I've been with the state.

I would hate to lose it.

I received one e-mail this morning from someone who has been with the state for 50 years and echoed that sentiment.

One retiree stated in my experience, I've not found a more efficiently operated plan than Blue Cross Blue Shield.

Are liability is paramount especially when navigating serious health challenges.

Will during my cancer treatment, the entire process was handled with the utmost professionalism and smoothness.

Furthermore, I have never encountered payment issues or hidden charges which provide significant peace of mind.

Several brought up that we have had issues with Aetna in the past, using so when Aetna was a can care Medicaid managed care organization.

>> CHAIR PROFFITT: Commissioner, I might pump you with state employee health stuff.

>> CRISTI CAIN: I can skip that.

Okay.

The I'm almost done.

So health insurance with choice and competition.

Competition drives better customer service.

Broader provider networks, more responsive plan and greater accountability.

When employees can choose insurers, must earn and maintain trust every year.

Moving to a single carrier model removes accountability and employee choice.

There's less incentive to control costs long term and fewer consequences for poor performance.

Employees lose their most important leverage, which is the ability to choose a different plan.

They are not inefficiency in the system, with removing them may simplify the structure, but it

increases risk, reduce accountability and ultimately limits the ability to meet employees needs.

So this discussion is not just about selecting a health insurance vendor, it's protecting access to care, maintaining trust, ask supporting Kansas jobs and ensuring the state blow employees feel valued, supported and able to stay in the workplace.

So I would like to thank you, Mr. Chair and my fellow Commissioners for allowing me to opportunity to share the concerns and experiences of state employees and your willingness to listen and consider these perspective.

I respectfully ask that as we move forward in our deliberations, y'all take into account not only the financial considerations, but also the real and meaningful impacts this decision will have on employees, their families and the work force as a whole.

Thank you.

>> CHAIR PROFFITT: Thank you.

Before I come back to you, Commissioner Dechant.

To repeat what you said, the comment about one particular provider not being in network who with Aetna, was that person's opinion we don't know that's a fact.

On the record for that.

Commissioner Dechant, did you have a follow up.

That thoroughly answer your question?

>> STEVE DECHANT: The question was answered quite thoroughly, thank you.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you.

I'd -- from the eac, because I got a communication that they had surveyed the members of the eac committee.

>> CHAIR PROFFITT: Had not planned on bringing anybody else up to the podium.

Call the eac to advise us, it would be okay in this situation.

Make sure you introduce yourself.

>> Hello.

Yes.

Ask the I'm Michael, I'm president of the Eac.

I did try to reach out to as many of you as possible.

I didn't have contacts for all of you, e-mail, my apologies.

Will I did survey all of the eac members, which represent a broad, diverse number of state employees from across the state on different plans, in different geographical regions and I heard 21 of us, I heard back from 17, and their comments very much reflect what Commissioner Cain's experience was in her e-mails.

I suspect that I got some of the exact same e-mails from other state employees in addition.

There is a large concern, a lot of worry out there about the loss of Blue Cross Blue Shield and what it would mean for continuation of care, provider access, a lot of people are worried that they already have to drive a long way, they'll have to drive even further, that might restrict their access.

People are worried about recruitment and retention of employees.

This is one of several aspects of employee compensation, and in addition to pay and retirement benefits.

For a lot of people, it's a very major one.

So the advice of the eac is to try to continue, if possible, with the status quo I'm a dollars and cents guy too, but at the same time there is a human cost to restricting access of employees to one provider over another.

The and if the first rule in health care is to do no harm, I think that going with one provider, through no fault of Aetna's, is going to do some number of employees some amount of harm, whether it's a few dozen or a few hundred or few thousand, I don't know.

Are statistics, there's a lot of numbers that have been thrown at us today.

But that is the positions of the eac.

Thank you.

>> CHAIR PROFFITT: Thank you.

Commissioner Sutton, did I see your hand up earlier or no.

I couldn't tell.

>> BILL SUTTON: Excuse me.

No actually I did -- I think I got some of the same e-mails.

I quantified mine a little bit differently.

Went with pro/con, so I didn't take note of the reasons for each of those.

But they put -- those news reports had my face on the front of it.

That was awfully nice.

I got a few responses myself.

Are but I came in predominantly I would say -- well, not -- I would say, it was exactly, I had 8 opposed, 4 who didn't care, and one who just wanted to know what was going on.

So that's what I got as far as response was concerned.

4 didn't really care, they thought the money aspect made a lot of sense.

Eight were about continuity of care.

Wanted to make sure we use provider in its correct terms here.

But only looking at insurance providers, not health care providers.

But that was the concern voiced most often in the 8 in opposition.

Thank you.

>> CHAIR PROFFITT: We are not ignoring you, Mr. Hensley.

Are.

>> ANTHONY HENSLEY: Mr. Chairman.

>> CHAIR PROFFITT: Can Mr. Hensley.

>> ANTHONY HENSLEY: I would like to go ahead and move that we maintain the status quo.

>> CHAIR PROFFITT: Okay.

Looking at counsel here.

>> ANTHONY HENSLEY: If I need to word that motion differently, I would be happy to do so.

>> CHAIR PROFFITT: Procedurally, I want to make sure.

You will likely need to word it differently.

We had a motion tabled last time.

I want to see if that takes precedence and we need to bring it back further.

>> ANTHONY HENSLEY: I make a motion to bring that off the table.

>> CHAIR PROFFITT: Okay.

So the commission there's been a motion to take from the table -- I'll state it for you, Commissioner Hensley, if you can approve it. To take from the table the Sutton motion from the April 15 meeting, is that correct.

>> ANTHONY HENSLEY: Yes, that would be correct.

>> CHAIR PROFFITT: So the Commissioners, this required a second.

It is not debatable.

Requires four votes in the affirmative.

If you -- again, this is to take from the table only, not to approve that motion.

The if we get four votes, that motion is back on the table and would be on discussion.

The if it does not get four votes, then it is left on the table in perpetuity.

With that, we will do a roll call -- I need a second, actually.

Second by Commissioner Sutton.

Mark those.

we will do roll call.

>> Before, if you would tell me what a yes vote versus a no vote.

>> CHAIR PROFFITT: Yes vote indicated you want to take that motion from the table and bring it back up for discussion.

No means it dies.

There is no -- this is not debatable.

Commissioner Cain.

>> CRISTI CAIN: No.

>> STEVE DECHANT: No.

>> ANTHONY HENSLEY: No.

>> BILL SUTTON: Yes.

>> VICKI SCHMIDT: No.

>> CHAIR PROFFITT: The motion fails.

Commissioner Hensley, you had a motion.

>> ANTHONY HENSLEY: I'd like to make a motion that we maintain the status quo in terms of what we offer for state employees.

>> CHAIR PROFFITT: If I can restate the motion too if you don't mine.

Your motion would be to accept the bids of Blue Cross Blue Shield of Kansas and Aetna as proposed, is that correct.

>> ANTHONY HENSLEY: That is correct.

>> CHAIR PROFFITT: Okay.

We have a motion, do we have a second.

>> CRISTI CAIN: I'll second.

>> CHAIR PROFFITT: Second Commissioner Cain.

Open for discussion.

I'm getting a look.

One second.

Commissioner Schmidt.

>> VICKI SCHMIDT: I substitute motion.

It be extended for one year only and take it back out for bids to see if we can get a more reasonable bid.

>> CHAIR PROFFITT: For clarification, Commissioner Schmidt, extend the current contracts for one calendar year, one plan year and rebid them next year. Why I want to make sure I get the motion right.

>> VICKI SCHMIDT: I hadn't thought of it that way.

>> CHAIR PROFFITT: I'll rethink it.

Don't want.

>> VICKI SCHMIDT: no, that's okay.

I didn't think of it that way.

The I -- that would be great to extend this for a year and go back out. Or to take -- I mean, because we can't take this you -- me current bid, can't take it for one year because the RFP was bid out for three years, is that correct?

>> CHAIR PROFFITT: Counsel, can we make it one year or three years?

Can you comes up please.

Question is ultimately can we accept this bid for one year or extend the current contracts by one year.

>> Okay.

Chief counsel for the Department of Administration.

The issue for the commission is that the scope of the RFP was for a three-year agreement.

So to take it down to one year, there was no -- there was no negotiation as to a one-year agreement.

There would be no requirement potentially of the vendors to accept a one-year agreement that would be offered.

You would put yourself in a position where, yes, you pass a motion, the vendors may say no, we don't

take that and you're right back here maybe next meeting having to have another vote to accept.

The -- to come back to the same RFP.

The so I'm not -- I mean, if you want to get into the legalistic of it, I think we would have to go into executive session to have a better discussion.

The point is, you could seem to amend, you are going against the initial scope and what was negotiated.

>> CHAIR PROFFITT: Thank you.

Given that Commissioners, your motion to extend the current contracts by one year.

>> VICKI SCHMIDT: Can we extend the current contract by one year.

>> You have the same potential with the vendors accept a one-year extension of the current contract.

I don't believe that's been discussed with the vendors at this point.

>> VICKI SCHMIDT: Well, I'm a betting person and I bet they would.

>> That wasn't my question.

>> VICKI SCHMIDT: I would extend the contract for one year, the current contract for one year and then take this back out for bid.

And hopefully -- never mind.

>> CHAIR PROFFITT: The motion has been made by Commissioner Schmidt.

Is there a second?

>> I'll second.

>> CHAIR PROFFITT: Second by Commissioner Dechant.

Discussion on the motion?

Commissioner Sutton.

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

My question boils down to why would we take it back out for bid?

From what I'm hearing, no matter what is offered, we don't want to cause any disruptions.

Even in the face of saving \$220 million, we would rather go in their next meeting and decide what copays we are going to increase, what coverage we are going to reduce, what premiums we're going to increase in order to keep our plan solvent.

My question, it seems to me we are going to -- that the will of the committee, and I could be wrong on this, it seems to me the will of the committee is whatever Blue Cross Blue Shield offers, that's what we're going to take.

I thought the purpose of getting a bid was to get the best deal for our Kansas employees and yes, disruptions does figure into that, absolutely.

But when we are looking at \$220 million, that looks to me like bang for the buck on that.

That's doing what we are supposed to be doing with an RFP, and that is trying to control the costs that are hitting our state employees.

The so my question would be why would we take it out for bid in a year?

>> CHAIR PROFFITT: Commissioner Schmidt?

>> BILL SUTTON: Just in general, anyone, really.

>> CHAIR PROFFITT: Keep that to the maker of the motion.

>> VICKI SCHMIDT: Sure, I would be happy to respond.

I think that -- I think we should do a better job getting the bid, and I think we ought to do a better job of somebody advocating for the State Employee Health Plan in some of the numbers that we are seeing.

I think by continuing it for one year, we can maybe convince people on the negotiating side to negotiate harder for the state employees.

The.

>> CHAIR PROFFITT: Commissioner Dechant, did you have a.

>> STEVE DECHANT: On the possibility that your bet doesn't pan out and the providers that we have before us would say nope, not interested, where would that leave us?

I don't know who to direct that question to.

>> VICKI SCHMIDT: Back to the drawing board.

>> CHAIR PROFFITT: Leave us without carriers if they both said no.

>> STEVE DECHANT: Then our choice would be to accept one of the options we have in front of us now?

>> CHAIR PROFFITT: We would have to decide at that point what we are willing to do and how we do it.

>> STEVE DECHANT: Where does that leave us, Jennifer in terms of timing and getting things and information to employees, et cetera.

>> JENNIFER FLORY: So we need the commission to have the decisions that affect open enrollment made by the June meeting so we have adequate time to complete implementation, prepare all of the open enrollment materials, get everything printed, mailed so that employees have the information they need to know about their health plan, starting October 1, when open enrollment rolls out.

>> CHAIR PROFFITT: I've got comments on this, and I don't generally weigh in, provide too many comments and don't generally vote, thousand may have to today. Might as well get my thoughts on the table.

Similar to what Commissioner Cain said, we received a deluge of e-mails, phone calls and other concerns, that this is even a discussion is this really going to happen.

Before I go there, let me make sure I couch this appropriately.

I don't see this as anti-Aetna or pro Blue Cross Blue Shield.

I want to make sure I'm not coming across as one of the vendors in front of us today.

That's a technical term.

My Chief of Staff, I've made him the point of contact for the Department of Administration for Any concerns, he received himself over 100 e-mails as of the middle of last week.

System received outreach of the eac. Received President of the Coast, organized labor who, saying please don't eliminate choice for state employees, from various cabinet secretaries who have employees all across the state on behalf of feedback collecting from employees, not just one secretary, secretaries on behalf of employees because they were expressing concern directly to them.

A noncabinet agency meeting the other day where we have all the noncabinet agency heads come in.

I asked if people had heard anything about this.

Employees expressed concern, yes, the point I'm making there is you combine all of these, I think we are well into the thousands of employees who have expressed concern of loss of choice of a provider.

We have 35,000 contracts with Blue Cross Blue Shield right now.

We have about 5,000, using round numbers with Aetna.

Whatever we show with the percentage of disruptions with providers, there is going to be disruptions as we have talked about, people moving carriers, potentially going to be moving physicians specialists, hospitals, we don't know for sure, we know that's a probability.

As it relates to choice, I think choice is important for providers protecting Kansas providers as well.

The if Kansas providers only have one carrier with whom to negotiate, if that negotiate goes poorly, they have no leverage to go to the other one.

We have talked about Aetna lacking a network today, the flip side of that, Blue Cross Blue Shield with a local hospital here in Topeka, were in at a contract impasse at the end of the year.

We they can move carriers, if that hospital is that important to you.

We do have a mandate in statute to provide a cost effective program.

We also have a mandate to make sure we provide the most robust and beneficial coverage for state employee and having that choice in my view is equally as important as a cost component, we have

talked about \$200 million.

With I'm not saying it's nothing, I'm obviously my role as Director of the budget, it's a big deal.

I'm painfully aware of the dollars and cents.

I try to be common sense as well.

It's not \$200 million increase we are asking for.

It is a \$200 million spread if we take a leap of faith and accept Aetna's bid, that they can make sure we have robust coverage and by broad network.

Not saying they cannot do it.

They told us they would have to start working on that.

It is a leap of faith in my estimation.

Scrap but the increase we are looking at for next year, 2.74 percent. Why that's on slide 12, is pretty close to what the target rate of inflation is.

Stated differently, if we maintain status quo and maintain two carriers and choice for our employees and listen to our employees feedback, we are staying on pace with inflation.

2027 blended.

So I'm not convinced that Aetna -- all due respect Aetna, I think they are a reputable organization, but to take on a seven-fold increase in contracts, I think it's more than that, just the contracts, doesn't take into account dependents.

That's asking a lot.

Not throwing away the \$200 million.

It's not an increase, if they hit these metrics, it would be a \$200 million save.

If we go with both, 2.74 percent increase versus where we are at today.

Again, this is not anti-Aetna, I'm not trying to be that way, trying to listen to the feedback of our employees, I'm trying to make sure we are balancing our dual mandate in statute and making sure we have choice for employees and have choice for providers.

If folks want to choose Aetna, that's great.

If folks want to choose Blue Cross Blue Shield, that's great.

Choose them.

But that's -- I have a strong opinion on this we need to maintain choice and candidly, Commissioner Schmidt, are I appreciate your motion and the intent.

I think what is the intent behind it.

Don't want to assume intent, but I won't be supporting it because I think incumbent upon us to make the best decision and protect the choice for the next three years. I will be voting down the substitute.

I -- I did get a vote.

The.

>> STEVE DECHANT: Thank you.

The second was basically get more discussion.

But it bothered me because we are collectively going to forget or collectively won't be here for the most part in three years, and those folks that are on the commission three years from now will just hear about it as that's what happened.

The and somehow I'd like to -- what I wrote down, point out the difference to the membership, that if there were enough members to choose Aetna, that we would have some impact, that they would have some impact.

There's something out of whack when there's potentially, by one bidder, a 200 to \$240 million difference.

And the procedures and statutes and regulations and bidding processes seem to stand in the way of being able to get two competitors in the room to duke it out and figure out how do we get to what really is a reasonable, fair all the way around in terms of persons lives, in terms of dollars and in terms of state taxpayers funding something.

The and somehow that's what I'd like to be able to get to, is -- we don't have the time to do that this year.

That's kind of why I like the idea of a one-year to say okay, this is what we want to accomplish, can we get the current vendors to go with this for another year and give us a shot to do that.

Because I don't -- I don't want to ignore either, and it seems to be the only way to get a blend of both the tremendous financial impact and the tremendous potential human impact.

So I think that speaks my piece.

To why I supported the substitute motion.

I do have one other question.

>> CHAIR PROFFITT: Go ahead.

>> STEVE DECHANT: Regardless, if we in some way accept the proposal and go with the blend, does Aetna's tiered -- at this many enrollees in Aetna, necessary gives this kind of a price -- does that stay?

>> CHAIR PROFFITT: Yes, the Aetna bid.

>> STEVE DECHANT: If Aetna picked up 10,000 enrollees, there would be a cost break even under the proposal, it's not an all or none with them.

>> CHAIR PROFFITT: Correct.

Getting nods from the staff.

>> STEVE DECHANT: Well, this may not be the point in time given the -- given the current motion on the board, but I would like to somehow point out to all 35 or 40,000 contract holders that they -- each and every one of those folks can have some impact.

We talked -- some of the comments talked about 90 percent can't be wrong.

I don't agree with it fully, but if people recognize that -- if they choose to make a change Aetna, they can have some impact in -- immediate in terms of decreasing costs to the whole system.

I don't know if that would be appropriate to point that out in the book, but there's lots of concern and worry right now in terms of one only, and everything that goes with that.

But there's a 2 -- I think it's more than 200, \$240 million difference between all and none or blended.

A big difference.

Sell I tried to do some numbers, and I think it boils down to \$1,000 per contract per year.

I'm sorry.

I'll defer to 1250.

So that's \$100 a month for folks.

That's nothing to sneeze at.

That's just to the employee side.

Will that same impact is happening to the state side.

So those are my thoughts.

And I share them for what they're worth.

>> CHAIR PROFFITT: Discussion before we move to a vote?

As a reminder, the substitute motion on the table is to extend the current contractual, by 12 months and rebid this next year.

We'll do roll call vote.

>> CRISTI CAIN: No.

>> STEVE DECHANT: Yes.

>> ANTHONY HENSLEY: No.

>> BILL SUTTON: No.

>> VICKI SCHMIDT: Yes.

>> CHAIR PROFFITT: I will reserve vote.

I'll vote.

I said I would Bo.

Chair votes no.

Two in favor, 4 against, the substitute motion fails.

Back on the original motion to system the -- to accept the bids as presented.

I might -- make a substitution most, Commissioner Hensley, it will be to.

>> ANTHONY HENSLEY: Back on the amendment.

Sorry.

>> CHAIR PROFFITT: I'll make a substitute motion that we accept the bids as presented during the bafo process with the option to have tiered pricing that will be determined some time in the next year, so we can offset the tiered pricing meaning we could -- the extent that the Aetna pricing appears less, we could have tiered pricing such that employees when they choose would see a price difference between the carriers, Blue Cross Blue Shield or Aetna, with a to be determined by the commission.

I might defer to Director Flory to make sure I'm stating that right.

>> JENNIFER FLORY: Yes.

We could -- we have historically not always had Blue Cross Blue Shield and Aetna priced the same amount.

In recent years, we have because when you add the additional costs to the Blue Cross Blue Shield bid for the value based benefits and for the blue card network, it may -- with Aetna's discounts and Blue Cross Blue Shield's extra charges, it made them basically the same.

We have had the same rates.

We actually can do a separate rates for Blue Cross Blue Shield and Aetna if the commission so approves.

>> CHAIR PROFFITT: My motion is to have the option to be discussed and priced out and determined at a later date.

That's the substitute motion.

Second by Commissioner Sutton.

Discussion on the new substitute motion?

Commissioner Sutton.

>> BILL SUTTON: I didn't even realize that was an option.

I definitely like that.

One of the -- actually two of the people I spoke with, the ones in person, not e-mails, said that if -- if it meant paying more for Blue Cross Blue Shield, then they were absolutely in favor of that, and while I philosophically disagree in that they are also at that point saying I'm okay with other people -- paying more, which I don't think they have the leeway to do, I don't think that's a license granted. However, if we have that -- the option that if you would like to stay, then you absolutely can pay more, and that's on an individual basis.

Then I am absolutely in favor of that.

Thank you, Mr. Chair.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: I just wonder how that works when we get to the next meeting and we are doing what the increase is, like if we are going to increase, I don't know, copays, and that would -- that would happen on both -- whatever decision we make, at the next meeting would happen on both networks, right?

Then we would have a split screen of what you do Aetna and what you do to Blue Cross Blue Shield?

>> CHAIR PROFFITT: Unfortunately, Director Flory stepped out of the room.

But to answer your first question, yes, any plan design changes we make at the June meeting will apply evenly to both of them, both carriers must have the same deductibles and copays, are but to the extent that we are making a cost differential between the two, we would have to figure out how that works, be a little bit of extra work, I'm confident we can get there.

Paul or -- come on up.

>> I'll jump in since Jennifer left the room.

There are multiple ways you can do that.

Do it in plan design or do it in premiums.

So it could be that you're talking about the same plan designs and then you make the differential in premiums.

>> CHAIR PROFFITT: Sorry, real quick.

Pete, our Deputy Director for finance has a thought.

>> Pete Deputy Director of finance administration.

Historically in the past when we have had that, had different employee premium rates, for the differentiated rates.

Will so just Blue Cross Blue Shield might be -- Aetna might be \$35 and Blue Cross Blue Shield might be 50.

Right now it's kind of what we would be looking at.

The plan design would not necessarily change, it's the -- as the chair said.

The copays and coinsurances and things would be the same.

It would be on the front end on what would be deducted.

Historically when we have had differential rates, that's what we have done per carrier.

>> VICKI SCHMIDT: When would we know the differentiated rates?

>> CHAIR PROFFITT: Are we -- are you able to adjust your model for the June meeting so we can have the two tiers.

>> We will start adjusting immediately, because it does take a while.

Yeah, we would -- we can do that.

>> VICKI SCHMIDT: Model and bring it back for June.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: My question would be so -- pardon me because I've looked at way too many things on these sheets here.

Is it like zero through 500 is one rate with Aetna and 500 to a thousand is another rate or are thiol the same rate right now.

>> All the same premium, it's all one premium.

All one premium.

this would be if you're a family on Plan A, you would have a premium option for Aetna or a premium option for Blue Cross Blue Shield is how I see it.

>> Those are two different things, ASO fees that you pay Aetna are on the sliding scale as to law many enrollees they are, but your funding rate, what you use at your rates and premium contributions to your employees are static, not on a rolling scale.

That doesn't depend on how many are enrolled in the plan.

>> VICKI SCHMIDT: Aetna is 100 percent was because they -- if they got 100 percent, they were the only sole provider, then that's where we saw the savings.

>> That was in their ASO fee.

>> VICKI SCHMIDT: So does the ASO fee doesn't come into the premiums.

>> It is part of the premium, yes.

The roll, then your starting point would come down.

>> VICKI SCHMIDT: I'm just saying we won't know what our enrollment is until we make the premiums.

So then the premium might not reflect accurately.

>> CHAIR PROFFITT: If I can make an assumption.

>> May I?

>> CHAIR PROFFITT: The way I understands it, we are -- it would increase revenue one way or another.

And the projections are going to be based on a assumption of enrollment.

But if more members -- making numbers up.

Say we increase the premium for Blue Cross Blue Shield by ten dollars, every tier, every type to the extent that folks stay enrolled with Blue Cross Blue Shield, that would generate more revenue by the virtue of ten dollars people Jim.

If more folks shift over Aetna, assuming we reach a new tier, you would then get -- you would have a reduction in expenditures, I'm trying to balance it by either new revenue with people paying more for Blue Cross Blue Shield or reduction should folks say no, I don't want to pay more, we have to Aetna.

please correct me if I'm way off base here.

>> No, that's correct.

We do have a difference in admin fees, but we have a difference in claims, and the claims, the 240-we were taking about here, the difference is 4 million a year.

>> CHAIR PROFFITT: Any other discussion?

So Commissioner Dechant.

>> STEVE DECHANT: I'm not sure I understands.

So who would set the monthly health insurance cost.

>> CHAIR PROFFITT: Director Flory, if you can help us out.

>> JENNIFER FLORY: So we would work with Segal to look at the discounts, because there are additional discounts in the Aetna bid, and we could present back to the commission differential in rates for the Blue Cross Blue Shield bid and then the commission would approve that.

We would not, as the employees in the State Employee Health Plan, Segal would not set the rate.

We would bring forth some suggestions to the hcc, and you all would pick what the rate would be.

So let's say it's the ten dollars we talked about.

So if the employee only cost today for a single person is \$20, is with Aetna, then it would be 30, with Blue Cross Blue Shield, if you the ten dollars differential, we would show that amount in the open enrollment book, then employees would vote with their feet as to which vendor they wish to select.

That way employees who are looking the biggest discount, they could move Aetna.

>> STEVE DECHANT: And then would an employee plus dependents or employee plus spouse and dependents be more differential.

>> JENNIFER FLORY: Yes.

It could be, if that's what you want.

Again, we could make it fit your needs.

Typically, you know, there's an employee only rate, there's an employee plus spouse rate, that takes into account the spouse's do cost a little more, employee plus children rate, taking into account the children tend to cost less.

The and then there's a full family rate.

We could -- we'll work with Segal to come with up some -- come up with some suggestions, but ultimately the committee could tell us how to proceed.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: That's what your motion is.

>> CHAIR PROFFITT: To provide the commission the flexibility to have tiered pricing, to be determined by the HCC at the plan design meeting.

Set up the difference in premiums by plan and type, so up to the commission what that price would be, set for the next plan year.

>> STEVE DECHANT: Great.

>> CHAIR PROFFITT: Seeing no more further discussion, we'll do at roll call vote.

>> CRISTI CAIN: Yes.

>> STEVE DECHANT: Yes.

>> ANTHONY HENSLEY: Aye.

>> BILL SUTTON:

>> VICKI SCHMIDT:

>> CHAIR PROFFITT: Fair enough.

I'll go ahead and vote.

Chair votes aye.

So with 5 in favor, are none against and one who abstention, the motion does carry.

The we will -- if you could e-mail the explanation of the vote to Director Flory and myself, that would be helpful, thank you.

>> Will that explanation be in the minutes then.

>> CHAIR PROFFITT: They'll be reflected in the minutes, yes, verbatim.

keep the length.

>> VICKI SCHMIDT: I will try to keep it brief, but, you know, I think that -- my substitute motion was the one to go with, but I do think that when you have such a vast range, between the two bids, there's something that isn't -- something just doesn't look right, and I don't feel state employees, when -- sorry, but when the legislature gave them a 1 percent raise, which isn't much and then we are talking about what our overall reserve looks like, about \$6 million, which is in the gutter, you know, then either the employees will have to make that up, in premiums, and that doesn't seem right, or the state makes it up, and that's -- the state general fund, that's taxpayers money making it up.

The so I don't think either one of those are good choices, and I think it should have gone back out to rebid and take a look at it and see what happened.

But I still don't have all the answers to all of my questions, and that is very disturbing to me that we have had multiple -- we -- I submit ted those questions and really wanted the answers.

I don't just sit around and think about how to make work for somebody.

They are answers I really want, and I don't think they were answered.

The so thank you.

>> CHAIR PROFFITT: I assume we are still waiting for a written explanation.

Very good, thank you.

Commissioners, next discussion item is a very, very brief overview of the plan design for plan year 2027.

Just kind of talk about -- Director Flory.

>> JENNIFER FLORY: So Pete, can you bring up the model.

We provided you in the addendum again, we provided a review of the rate and plan decisions that have been made over the last six years from 2020 to 2026.

We provided you in the addendum, the member cost share data for plan years 2024 and 2025.

The point in doing that is to show you how many employees actually meet their deductible and how many of them meet their out of pocket because if you decide that you want to make a decision to increase deductible, say, on Plan N, you're going to see that the impact is very small.

Because there are very few people on Plan N that actually meet their deductible today.

So we wanted to share with you that additional information.

So that you have a good idea some of those impacts and how they may work out when you look at the number of individuals that actually meet those criteria today.

So with the model today, we have -- Pete can you put us on the choices?

There we go.

Here's some of the choices that we have just thrown out there.

Again, these are in your book and we sent these out to you all.

If there is something specific not on this sheet but which you would want to see on this sheet for the June meeting, we need to know as quickly as possible because it does take some time to do the configurations to update the model with accurate information.

So we are asking that you get those changes to us preferably by the end of this week.

Because we have asked -- this is the third time we have now asked for those.

Will if there is something missing from the model you want to see, we are more than happy to add it.

It does take some time to get the information together to get the model updated.

So that's really all I wanted to show you, was again, these are the choices we have today, if there's something missing that you would like us to add, I need to know by the end of this week.

>> CHAIR PROFFITT: Thank you, director.

We received quite a few already.

We initially asked for them the end of day today.

Let's do it this week. Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman, I would like for everyone to really take a close look at the GLP-1s.

If we left the GLP-1s as CVS has instituted it now, which is not what I think the commission intended, are and I think CVS didn't do us in I favors by -- did us no favors by not coming forth when we were discussing that our proposal to talk about the rebates, but if we leave it as it is now, it costs every employee of the State Employee Health Plan \$46 a month, even if you're -- if you're not receiving GLP-1s, that's the cost to each and every employee, is \$46 a month.

Will so I'd ask that you consider that when you're looking at these things, thank you.

>> CHAIR PROFFITT: Any other discussion?

Okay, seeing none, again, as a reminder, in case anybody stepped out or missed that, any plan design changes that in the model, by the end of this week, plan design changes, ask I should say, we'll spend a good amount of time at the June 2 meeting discussing those.

All right, again, discussion next meeting, June 2, at 9:00 in the morning.

Not 9:30.

9:00 in the morning.

So 9:00 in the morning on June 2.

I say this seriously, plan for a lengthy discussion just because I know these are always robust discussions, only to the benefit of our employees in our plan.

With that, there is material that had a few items of follow-up, those are in your books and in your PDF.

with that, we would welcome a motion to adjourn.

>> So moved.

>> CHAIR PROFFITT: Is there a second.

>> CRISTI CAIN: Second.

>> CHAIR PROFFITT: All in favor, say "aye."

[ chorus of ayes ]

Any opposed?

We are adjourned, thank you.