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>> CHAIR PROFFITT: Testing the mic.
Commissioner Hensley, are you able to hear me.
>> ANTHONY HENSLEY: Can you hear me?

>> CHAIR PROFFITT: Great success, we got you, thank you, sir.

>> ANTHONY HENSLEY: Uh-huh.

>> CHAIR PROFFITT: First item on the agenda approval of the minutes from the May 11 meeting.
There are any edits to the minutes?

>> I move we approve the minutes as presented.

>> CHAIR PROFFITT: A motion, is there a second.
>> CRISTI CAIN: Second.
>> CHAIR PROFFITT: Second by Commissioner Cain, all in favor.

[chorus of ayes]

Any opposed.
Minutes are approved.

All righty.
Team we are going to move -- commission, we'll move into item No. 2 on your agenda, which is the preferred lab vendor contracts, RFP.
This should be in tab 2 of your books and I believe Director Flory will walk us through.
Director?

>> JENNIFER FLORY: Let's go to the next slide, Pete.

so the preferred lab program is available on plans a C J.C., j and n.
This is an optional program employees do not have to participate and use a preferred lab vendor if they don't wish to.
There is no premium or administrative fee for this program.
Essentially how this program works is that we negotiate with some lab providers, and obtain preferred pricing for our membership.
We work with our tpa's to upload those files so any time one of our members uses one of those preferred labs, that preferred pricing is applied to the bill.
On the member side of the house, Plan A members, they get their lab paid at 100 percent of that negotiated rate when it's billed by that preferred lab vendor to their insurance company.
Plan C, j and n, those employees, because the high deductible health plan requires them to meet their deductible first, the deductible is applied first, but it is that preferred pricing, so they do benefit from this contract if they use that preferred lab because that amount they're charged is lower.
After they meet their deductible, then the plan pays at 100 percent.
Next slide, Pete.
We submitted the RFP and received three responses, these are the incumbent vendors which are Qwest diagnostics located in the metro Kansas City area, Stormont Vail health, which is here in Topeka but operates in a number of counties around the Topeka area, University of Kansas Health Systems, which operates in the ku med center as well as St. Francis here in Topeka as well as they have a hospital in Great Bend.
Anyway the University of Kansas Health Systems is operating, lab provider, our members will benefit from that program.
On the next slide, we did look at the benefits, we look at the access to quality care, quest is a statewide and nationwide provider of preferred lab services.
Obviously Stormont Vail and the University of Kansas Health Systems are regional providers.
We look at their capacity, and the discounts that they're offering, these are nonemergency lab tests, done on an outpatient basis that we receive these discounts.
Next slide.
We just went over this basically.
These are the counties where you will find our preferred lab vendors, again, quest is statewide and nationwide, Stormont Vail has a region here in the Topeka and tukhs.
With Barton, Johnson and Shawnee and Wyandotte.
We looked at the lab procedures, so we have a lab file of procedures, and we asked our friends at Segal to help us in evaluating the discounts and savings associated with this program.
And so for 2025, this benefit, we had 221,134 lab procedures processed under these benefits receiving those discounts.
The process goes that the claim goes directly from the preferred lab vendor to our third party

administrator so there are no fees.
The vendors then just process the claims at those evaluated rates and as a result, the savings estimate for 2025 was over $5 million using this program.
So that 2025 utilization numbers were used to project savings going into the future.
There's always, as procedures change, the mix may change, where people go may change, so those are just estimates, on the next slide we are projecting the savings using that historic file.
So we project with quest it would be 8.5 million, Stormont Vail almost 5 million, and tukhs almost $3 million in savings.
They are broken out by year so you can see the savings estimates, based on best and final fee schedules which they have submitted with their bids.   With that, I'll turn it back over.
>> CHAIR PROFFITT: Very good, thank you, Jennifer.
Any questions?

Commissioner Schmidt?

>> VICKI SCHMIDT: Mr. Chair, I was joss wondering on the savings, like is   -- does quest process laboratory -- I'd like to see it broken -- not every test that's given, but is one vendor less expensive than others?
On specific lab procedures?
I mean, this is just an overall thing.

>> JENNIFER FLORY: I can't answer that off the top of my head.
We do have Gina Sanders with Segal.
Melanie will answer it.

>> CHAIR PROFFITT: If you can make sure your Maine SILC is on.
>> There's the light.
So I did, when we did this analysis we did go ahead and process -- go ahead and bump all of the lab services against each individual carrier to see what would it be if all services.
Even those that are currently processed at nonpreferred labs, any of the services that would have hit their fee schedules they were all very similar if they would have all taken all the lab services.
There are going to be some services where one has a better deal than the other, but when we looked at all the services that were processed that would be eligible for theses discounted rates and we applied them to the different vendors, they came up very similar.
So in total, very close.

>> CHAIR PROFFITT: Any other questions?
Seeing none, I would entertain a motion, should there be one.
>> So moved, Commissioner Cain.
>> CHAIR PROFFITT: For what.
>> CRISTI CAIN: For proceeding with all three for the bids for all three.
>> CHAIR PROFFITT: The motion   to award the bid to all three that submitted and proposed here.
Is through a second.
>> STEVE DECHANT: Second.
>> CHAIR PROFFITT: Any discussion?

Seeing in un, roll call vote.

>> CRISTI CAIN: Aye.
>> STEVE DECHANT: Aye.
>> ANTHONY HENSLEY: Aye.
>> BILL SUTTON: Aye.
>> VICKI SCHMIDT:
>> CHAIR PROFFITT: Motion carries.
Contracts are approved, thank you.
The
all right.

next item of business, in tab 3, the pharmacy transparency vendor contract.
Director Flory on the floor again.

>> JENNIFER FLORY: Okay.
Next slide, piece.
So the pharmacy transparency tool is to designed to assist our members in helping them evaluate opportunities to find more cost effective prescription drugs.
So members have access to a concierge service with the current vendor, which is rx savings and can contact rx savings if they have a question about their prescription, if they are interested in finding out if there's a lower cost alternative, if there's a generic, if there's an opportunity in any way for them to change dosage or any way to reduce the cost of the prescription medication.
Also the vendor reaches out to members.
So they get a claims feed from our pbm and evaluate that information and if they see an opportunity where a member could save money, then they will reach out to the employee using the method the member has selected.
So they may text them, they may send them an e-mail or may call them and tell them that they have identified a savings opportunity and then it's up to the member to contact the vendor and they will discuss that option.
If the members, upon learning about the information, they can either contact their physician directly to have a conversation about that potential switch or they can ask rx savings to do that for them.
With the proper HIPAA forms filled.
Out they can contact the physician and have a conversation about the recommendation they are making.
This service is available on all of our plans for active employees, a, c, j and n.
The current vendors rx savings solution, we did submit this and only their bid was received.
It is kind of a unique market so I don't know that there's a lot of bidders out there.
But we did only receive a bid from our current vendor.
On the next slide, we had this program in place since 2015.
For 2025, rx savings they feel we have saved $3.6 million using this program.
Of that the state share AI 2.4 and the members is 1.1 million.
We have a really high member engagement rate with this program.
This is a program that you go out and register an account, we do provide health quest credits for members who have an account registered, so it is a very popular thing to do.

The so we have over 50 percent of our employees have an account.
That means that they have rx savings has the savings for those Virginia and allows them to contact them about their medications.
Rx savings reports that 49 percent of our members who go out to their website return at least once to do additional research.
We overall have a 60 percent engagement rate across our member portal, inbound calls and the pharmacy outreach.
We have very high engagement with this program currently with our program.
On the next slide, what we were looking for in this bid was, what did the customer service and member outreach look like, what services did they offer.
What's the potential for member and plan savings.
Obviously the cost of the program.
Then we needed to have a member friendly website with single sign-on and reporting.
So this bid includes access to their patented software services to identify potential prescription savings, member support, the my prescriber concierge service I've described. The member portal.
They do online trainings as well as participate in the benefit fairs during open enrollment and meet with employees and have one on one conversations with them.
As well as a direct mail program.
On the next slide is the proposed rates.
It is $2.34 per employee per month, which is set for all three years of the contract.
This is a reduction over our current fee, which is $2.45.
And this is based upon the assumption of our number of contracts that total dollars.
We took that pepm times 39,393 contracts to come up with the annual and three-year contract rates.
I'll turn it back over to you.

>> CHAIR PROFFITT: All right.
Thank you very much.
Any questions.
Commissioner Sutton?

>> BILL SUTTON: Thank you, Mr. Chair, just to clarify.
When we are assuming the 39,393, is that the current number as well.
>> JENNIFER FLORY: That's the current number of contracts we have today.

>> BILL SUTTON: The price is going down then.
>> JENNIFER FLORY: Yes.
>> BILL SUTTON: Very good.

>> CRISTI CAIN: I had a question on page 21 where you said that the 2025 program savings was 3.6 millionish.
And that was promise rx savings themselves.
>> JENNIFER FLORY: Yes.
>> CRISTI CAIN: Has that been independently verified by Segal.
>> JENNIFER FLORY: It has not.

That was the number they reported.
>> CRISTI CAIN: Is there a way to do that.

>> JENNIFER FLORY: We have had that conversation.
It will be challenging because sometimes the savings results from like pill splitting which I'm not sure how easy that would be to identify on a file.
If that is something the -- that the commission wishes, we could -- we were hot it contract coming up this summer, we could put that in as on ad it if that's something you would like.
>> CRISTI CAIN: Thank you.

>> CHAIR PROFFITT: As Jennifer noted, had a pretty lengthy of that, we have the ability to verify that, having the conversation this summer about the audit contract that might be wise for us to make sure what we are getting is what we are actually getting.
Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you.
Well, as a follow up to that, I'm wondering, in that 3.6 are they counting if I -- if a patient changes from drug a to drug b on their suggestion, then are they counting all of the refills or just the initial fill that they're counting. I think there's a lot of things we don't know about the 3.6 number.
>> JENNIFER FLORY: It does include the refills.

>> VICKI SCHMIDT: They project out they'll continue on that -- I mean, I think -- I think that rx savings would be more than happy to supply us with the -- where they're getting that number.
I think it's kind of irresponsible for us not to know how they're getting that number.
But they -- it should be a very easy spreadsheet.
If you I think what, you save this much money, if you didn't, you didn't save any money.
I hope that we can either pursue that with rx savings solutions or with the audit.

>> CHAIR PROFFITT: Thank you, I think a combination of both might be wise.
I think a combination of both might be wise.

>> VICKI SCHMIDT: Yes, sir, I think that would be great.

>> CHAIR PROFFITT: Any other discussion or questions?
Seeing none I would entertain a motion should somebody have one?

Commissioner Sutton.
>> BILL SUTTON: Thank you, Mr. Chair, we received one bid, I propose we continue with the one bid.
That is my motion.

>> CHAIR PROFFITT: Is there a second?

>> STEVE DECHANT: Second.
>> CHAIR PROFFITT: Any discussion?

Hearing none, we'll do another roll call vote.
>> CRISTI CAIN: Aye.
>> STEVE DECHANT: Aye.
>> ANTHONY HENSLEY: Aye.
>> BILL SUTTON: Aye.
>> VICKI SCHMIDT: Aye.
>> CHAIR PROFFITT: Motion carries.
And as the motion carries, we'll award that bid.
Jennifer I would like to request rx does provide more detailed information.
We might have an offline conversation.
The
I think it would be helpful.

all right.
Commissioners, moving on to No. 4, are voluntary insurance contract, this should be in tab 4 of your books and Director Flory, this item is yours again.

>> JENNIFER FLORY: So the voluntary benefits are insurance contracts that are available for employees to elect during open enrollment.
These are supplemental type of insurance products.
The they are entirely paid for by the employees.
They include an accidental injury, a critical illness or a hospital indemnity insurance contract.
The these are available to all of our active employees, and the member pays the premium for them.
So on the next slide just to provide a little more detail, the accidental plans provide a lump sum benefit if a person has a specific accident.
These dollars are paid directly to the member and me member can use them as they wish.
The critical illness policy, again, pays a lump sum if an individual is diagnosed with some type of critical illness or disorder, cancer, coronary artery disease, et cetera.
Again the money is paid directly to the member to use in the manner they choose.
And the final one a hospital indemnity plan that pays lump sum benefits when an individual is a bed patient in a hospital.
Those, again, benefits paid directly to the employee to use as they wish.
On the next slide, a little bit of history about these programs.
The health plan began offerings the these in 2017.
Our current vendor is MetLife.
Our enrollment numbers are listed before.
The March 2026 enrollment numbers so you can see that we have quite a number of contracts.
On the next slide, we'll show you the history that shows you that theses have been incredibly popular with employees, as you can see each year the number of contracts has increased.
We had Hartford in 2022, then 2022 and 2023 and then we have had MetLife for 2024 through 2026.
Again, the contracts have increased on all three products during that period of time.
These are -- this is a group platform.
These are rates that are available because they are employees of the state.
So they are more favorable, they have the opportunity to do payroll deduction, most of them are guaranteed issue, there are no health statements or preexisting condition limitations, no waiting

periods.
We do have a single point of contact if there's a need for claim support.
They have customer service available, both online and through their customer service center.
And the members are able to add their dependents to these plans as they wish.
Their coverage level for theses plans does not have to match what they have for their medical insurance with the state.
So we received forbids.
The bidders on the next slide are Aetna, colonial life, MetLife and The Hartford.
We had finalists meetings with all four vendors.
On the next slide, what we were looking for was the benefits offering, the cost to the member, the ease of the claims process, customer service, rate guarantees, and their ability to provide a statewide product that they supported with our members.
So on the next slide we have some bid exceptions.
The there were no exceptions with Aetna.
There were quite a few with colonial.
One of the issues that we were not able to resolve with them, we do normally review a vendor's report which provides us an outline of their financial and some of their computer security information, and we were not able to get that from colonial.
They wanted us to sign a -- it wasn't a waiver exactly, but it was a confidentiality, nda type of agreement, and we tonight do that.
It's that just our policy that if you want to do business with us, you need to provide the information.
So you can see there's a number of them with colonial.
With Hartford, we did want to note that they had proposed a $100,000 annual cap on performance guarantee payouts.
I don't -- I would be very surprised if we would ever reach that kind of a cap because typically that's performance guarantees are designed to ensure we are getting good performance not to generate revenue.
The and they also put in a provision that said that they had the ability to change the rates up or down 10 percent if our population changed by 25 percent.
So, again, depending on what would happen, it is possible if we were to gain, like, several large school districts, our population could go up by 25 percent, but probably not super likely.
And then there were no exceptions for MetLife.
So on the next slide, we asked Segal to help us with the rates for theses particular programs and so we have ranked them by the plans as 1 being the one that is the most cost beneficial to our member with 5 being the highest cost plans.
So you can see that both Hartford and MetLife each had three plans which they were the least expensive on and two plans which they were the second least expensive on.
And then behind there, we have the rates for all of the individual plans.
Secretary, did you want to go through all the individual plans?
No.
Then I will turn it back to you.

>> CHAIR PROFFITT: Any questions for director Flory?
Again, these are voluntary benefits, the members elect to either choose them or not choose them during open enrollment and the entirety of the administrative fee is carried by the employee, not by

the plan.
>> JENNIFER FLORY: Correct.
Paul pointed out that theses rates do -- is it Hartford and MetLife both represent a reduction in what is currently being offered, the price is lower than what we currently see.
On further back, if you want to know about utilization, back on page 43, we actually have the utilization currently for theses types of plans if the commission is interested.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: Have we had any concerns or issues raised in regards to our current contractor.
>> JENNIFER FLORY: I'll let Paul answer that because he works directly with members.
>> Paul Roberts.
We typically see occasional concerns or issues that pop up from time to time, just like we see on medical plans, but I would say on average, we probably don't have more than 10 or 12 a year out of 39,000 -- or 30,000 contracts.
The so it's not significant, but you can look at the utilization and see the number of people who actually make claims too.

>> CHAIR PROFFITT: Commissioner Cain.
>> CRISTI CAIN: It's my recollection that we have the fsa/hsa program for free with MetLife.
That they're throwing that in as an extra benefit.
Is that because of these plans, this business, does that -- that's not correct.
>> JENNIFER FLORY: Those are all bid independently, and we contract independently.
So this is not -- our coverage with the fsa and hsa is not contingent on this.
These are all separate and individual bids.

>> CRISTI CAIN: Okay.
I think I'm still confused.
How is it that MetLife is providing that service then at no cost or am I not recalling that correctly.
>> JENNIFER FLORY: You want to take that secretary approaches it's a good question.
I'm trying to recall the specifics of the discussion last year.
I would be speculating if I said anything.
I have thoughts on how it occurred.
But it's our current contract.
I expect that to be the contract moving forward.

>> CRISTI CAIN: I guess my question then was that is not an extra benefit then that we would get from MetLife if we moved forward with MetLife that we may not get with the others.
>> JENNIFER FLORY: Yeah.
The other contracts are not contingent upon this.
This is totally stand alone a separate bid, we have separate contracts.
So they're not tied together.
It's not -- we don't get this you for free because you buy this.

>> CRISTI CAIN: Okay, thank you, Director Flory.

>> JENNIFER FLORY: Yeah.
Paul points out they we actually were getting it for free when we had Hartford.
They're just separate products that are bid independently and contracted independently.

>> CHAIR PROFFITT: Open to a motion if any Commissioners would like to make one.
>> I move that we award the contract as presented to MetLife.
Is this a three-year term again.
For a three-year term.
>> CHAIR PROFFITT: You've heard the motion.
Is there a second?
Second by Commissioner Sutton.
Discussion?

seeing none, we'll move to roll call vote.

>> CRISTI CAIN: Aye.
>> STEVE DECHANT: Aye.
>> ANTHONY HENSLEY: Aye.
>> BILL SUTTON: Aye.
>> VICKI SCHMIDT: Aye.

>> CHAIR PROFFITT: Okay.
Motion carries, bid will be awarded, thank you very much, detect Director Flory, thank you, commission.

all righty, we are a little ahead of schedule, my plan was to take a ten-minute break for a couple of reasons, one to break into the meeting because we are moving into the meaty part which will take longer than 30 minutes.
I think Segal will need a little bit of time to get the spreadsheet pulled up and get everything switched over.
I'm looking at Segal to see how we play this, we can do the report first and take a break or if you need time to set everything up.
>> Whatever the commission would like.
>> CHAIR PROFFITT: Let's go through the financial report and then take a brief break.
Introduce yourself for the commission.
That would be great.
>> Melanie englebee with Segal.
I'm representing Segal today.
Going to go through the financial report.
I know the Commissioner said we are a little ahead of schedule.
I know we have a jam packed meeting today, I'll try to be somewhat concise, starting with -- this looks very similar to what you saw at the last meeting.

So there's no major surprises that came through.
It would be additional two months of experience, when we look at the experience for the first four months of 2026, we had a slight revenue gain of .7 million.
Program expenses are coming in about 6.6 million more than what was originally projected.
This is evenly split around pretty evenly split between the medical and rx claims, the ending balance at the end of April is 41.1 million, which is about 5.9 million below what the original projection was for that time period.
Looking at the enrollment, very little changes in the enrollment.
This is generally pretty steady.
See just a slight decrease in April.
The so there is on the average about .2 percent less through April.
Looking at April itself, be it was about .4 percent less, this does flow through to the projections, but roughly neutral.
The so just a slight dip there.
But nothing significant.
And looking at that multi-year projection summary, looking at the balance, projected balance for the end of 2026, we have a projected balance of 7.2 million.
This is compared to the 6.5 million that we presented to you the last meeting.
So just slight improvement there on that 2026 balance.
Looking out to 2030, it's targeting that 10 percent reserve at the end of the 2030 and we do still see the negative balances projected for both calendar year 27 and calendar year 28 under this funding.
And just a reminder you've probably heard it a million times now, but that in 27 there are 53 payments instead of 52 payments which is why medical claims see a bigger bump there in calendar year 27 than we would generally see year over year.
As far as how this affects the funding, targeting the 10 percent balance reserve at the end of 2030 the funding rate is calculated at 8.7 percent, just a slight bump of .1 percent from the 8.6 percent that we discussed at the last meeting.
This does, as a reminder result in negative balances in both 27 and 28 at this funding rate.
The if we were to target a zero dollar balance in 2027, if you were to spread the increase evenly for employers and employees both would need a 13.3 percent increase.
If you were to target a zero percent increase for employees, the employer increase would be about 18.1 percent.
One note I do want to make about that reserve balances, these are year end reserve balances, is so for targeting a zero dollar year-end reserve balance, there's very much the possibility there would be a negative balance at some point in the year.
So just wanted to clarify that.
That is the year end target we are discussing there that the model is solving for.
So it does not necessarily represent the lowest balance that you would experience in a plan year.
Looking at the sensitivity any time we are projecting claims out, multiple years, those projections are going to be sensitive to the trend assumptions.
If we look at plus or minus 1 percent, the range of reserve balances is 4.1 to 10.4 million.
If we go all the way out to 2030 that range gets much larger with the adverse scenario resulting in a 16-point -- negative $16.3 million balance, and the positive scenario resulting in a growth to 163.3 million.
So very sensitive to that trend assumption.

I would call your attention to calendar year 27 and just point out that under this funding rate, all scenarios result in a negative reserve balance in 2027.
If we experience the adverse trend of 1 percent higher at the end of the 2030 and the negative $16.3 million balance, you would need approximately 9.8 percent in 2031 and 2032 to make up the short fall.
And then the last chart there, just shows the impact of a million dollars, this is the impact of a million dollars on current claims.
The so for every million dollars that claims are above what's projected, it has about a .1 percent impact to that funding rate.

and I would be happy to answer any questions.

>> CHAIR PROFFITT: Thank you, Melanie.
I just want to piggyback on one of the items you talked about.
We discussed this on a call recently. The number the reserve plans you're should showing are end of calendar year, there's a potential they could go negative at some point during the year in these scenarios.
This discussion as Commissioner Dechant asked this question.
From an accounting perspective and state accounting perspective, there is -- it wouldn't be the only fund, there is a mechanism by which the accounting team can turn off the control to put a hard zero, such that it can't two negative during a fiscal year.
We don't like to see an account hold a negative balance across fiscal year, are June 30, there is a mechanism we can employ where we set a receivable against that.
The auditors need a clean trail to show the receivable occurs so we can close out that receivable and make it a positive balance.
What I'm not advocating for is letting us go negative in the year.
So piggyback on that, thank you.
Any other questions, Commissioner Schmidt.
>> VICKI SCHMIDT: Thank you.
Melanie, on the calendar year 2025 -- I don't have page numbers on this one, multi-year projection summary, and so we have gone from $37.5 million in reserve to 7.2.
Can you pinpoint a couple of things that may have affected that dramatic $30 million drop.
>> I can.
One thing I would just -- that's the projection just so we are -- everyone's on the same page.
Currently we have 41.1.
So currently we are slightly above where we ended that calendar year balance at.
Pretty typical as generally when you look at claims, the back half of the year is going to be heavier than the front half of the year as members move through their phases, but we are seeing higher than -- higher medical trends and higher pharmacy trends.
We did dig into the pharmacy trends because as you are aware, and we are seeing improvement in your GLP-1 costs, but what we are seeing, you have very large trends on specialty drugs in the pharmacy space right now, and so that is really what's driving that pharmacy piece, and that is a huge driver of what is deteriorating that fund.

>> VICKI SCHMIDT: I don't know what aom is.

>> The anti-obesity medications, the GLP-1s we have been talking about.

>> CHAIR PROFFITT: Thank you.
Commission what we will do now is take a pause, let these numbers kind of soak in, we'll get the spreadsheet pulled up, so let's take ten minutes, we'll say, come at 9:50.
And we'll have the spreadsheet and ready to go and walk through a demo and get going.
We are in recess until 9:50 a.m.

>> CHAIR PROFFITT: Pete, are we in a good spot?
Are we recording and zooming, okay.
All right, we are going to call the meeting back to order.
And next item of business is the 2027 plan design and rates. So this -- I like to start this one a refresher course on the spreadsheet.
The static version was sent out to everybody, a week or two ago, I think, last week probably.
So you can kind of see what the layout is.
As a reminder, there are several tabs, if we can go to a plan change summary tab.
This is one that has, I think most of these are just kind of thought starters.
If there were any special requests any Commissioner submit ted by the deadline that we requested, they would be on here.
What you see is a description of the potential change, again, these are all potential changes, doesn't mean we are going to do them.
What the change would be and in column b, if we decide to move forward with one, even just want to see one and what the impact would be, we change the no to yes and highlights the costs and savings shows you what the net impact would be, negative, so in that instance, change it back to yellow, if we did decide to increase the deductible on Plan A from 1,000 to 2,000, the plan would see a savings of one point will $72 million, and I -- $1.72 million.
And 2.2 million and so on and so forth.
Using an idea of what each individual change would do.
Scroll down, we have Plan C, so we can do this by plan.
One thing I'll note is on the high deductibles, we have modeled there on row 26 it looks like, the -- is it the member plus coverage, increase by hundred dollars as required by the I.R.S., we found out I think yesterday.
That does have to move from 3400 to 3500 on the individual only.
For us to be compliant with the I.R.S.
So I'm not going to make the motion now, but at some point I think it would behoove us to be compliant we this I.R.S.'s new guidelines so we don't lose that benefit.
That's one we will have to do.
If you go to the one that has the percent changes.
This is a little bit new, and I might get over my skis and ask Melanie to jump in.
This is what she was talking about where you have the employer percent increase and employee percent increase, the potentials and we start with 2027, right now she has those baselined at 88.7 percent increase in plan year 2027.
I believe that trues up to the model she just reviewed and all the projections she just reviewed, has 8.7 baseline across each of the years, this is where I'll probably need your help.

One change that we can Tinker with, we don't have to, when we approve the contracts at the last meeting we did so with an option to have tiered pricing should the commission choose to so.
So Melanie, if you can walk us through what that looks like, that would be helpful.
>> Yes.
So there's two positions now.
So the tiered pricing the secretary was just discussing is the potential to have a difference in the rate change for employees on the Blue Cross plan versus the Aetna plan.
And there's -- I'm going to actually suggest we look at the predefined difference.
There's another option, but I think this is where we're probably going to live here.
, it's populated with the 10 million.
You can put that in at whatever you would like it to me.
The model will calculate what fund I see is necessary to meet that balance.
Then it will still balance you out to the to percent to 2030 and allows you to put a requirement on the balances now and that end point and combine these pieces, you can say we want to meet the minimum balance, but we want to go back to where the increases are the same.
In this scenario, it will meet that $10 million balance, but it will calculate equivalent rate increases for the employer, Aetna and Blue Cross, or you can change this back to say we want to define the difference between Aetna and Blue Cross and we want 89 percent here and 6 percent here and then what does the employer have to do in order to meet the $10 million target.

>> CHAIR PROFFITT: I want to make sure -- correct me if I'm wrong here, we discussed is the other day, should the commission choose to do tier pricing in 27, each individual year is an increase from the previous year.
So to say that differently if you did 8 and 6 in your example, the next year if you did 8 and 6, you're starting from a different place already and compounding that.
It's not 8 and 6, it becomes 8.2 and whatever the numbers are.
So I just want to make sure we are clear on that, if you wanted to do one year test, leave the out year increases alone.
I don't know that we'll vote on that.
It is a compounding effect as you start to stack the increases.
>> One thing I would add to that as well, even if you do it this year and next year you have the same increases, you're still going to see that same compounding effect.
If you do different increases and next year the increases are the same, they are still at different starting points.
They would still be getting different dollar increases because to say one of them is ten dollars and one is $12, if I increase them both by 10 percent.
And so you would still see that gap widen going forward.
>> CHAIR PROFFITT: Thank you.
Then there is a near Joe which we can back solve for the employee increase, we could increase the employer contribution or whatever we want and let the employee contribution calculate.
>> Yes.
It still has the -- let's see.

>> CHAIR PROFFITT: Right now it's solving for the employer.

>> If you do the fix for the employer, it would.
It's a little bit -- it goes a little bit -- sorry, say what you wanted to do one more time.
>> CHAIR PROFFITT: We are solving for the employer rate increase by using the employee rate increase, the variable.
We could use the employer rate increase as a variable to solve for the employee increase?
>> Correct.
It has the functionality you've seen in the past where we can change these to fix, we can fix the employer rate increases, it will not change those.
Then you can solve for what the employee rate increase would be, if you have that increase.
>> CHAIR PROFFITT: I can't see the first half, there's a chair in the way. I believe that's where the dollar impact of the pepm.
>> Correct.
We have this lovely chart here for you that shows the increases in all of the rates.
So you have the employers as well as the employees, so down here we can kind of scroll to show and we may need to fix some.
Yeah, we may need to fix this so you can see the plans. Down here you can see where the rates are and then it shows in this scenario this is the 8.7 showing the same increase to both Blue Cross and Aetna.
You can see here they are both the same, both 88.5 and over here it shows you what the difference in them is on a dollar basis.
The so if you do decide to explore different rate increases for the two carriers, this tab will show you exactly what the result of that is and what the difference is between those two plan offering as the employees would see it.

>> CHAIR PROFFITT: Thank you.
Commissioner Schmidt, did you have a question, did I see your hand, okay.

>> VICKI SCHMIDT: Thank you, Mr. Chairman.
Well, I guess my understanding was that you were going to model some premium rates that were differing -- that did differ by carrier and take into account the bid proposals and the administrative charges and the provider discounts that were being offered for like Aetna because we saw such vast differences.
So I'm a little confused, what is your recommendation, I don't want to just pull it out of it hat and say one should be 10 and one and.
What are you're recommendations because you guys said you would get that to us by this meeting and I haven't seen that.
>> So we do have -- we did look at what those -- what the differences would be, and in discussions with the secretary, we didn't make a recommendation.
The I think he has some thoughts as far as the differentials, but when you look at the pricing, essentially what happens is when you look at it based off of the bids, the difference is about $150 per month.
Per contract.
And so the differential that would be, put in place if we were to follow what those financials are, is very, very large.
And is -- I won't presume but is likely beyond the will of the commission.

And so we do have those.
>> VICKI SCHMIDT: It's likely what.
>> I won't presume, but I assume it may be beyond the will of the commission to put in the 150.
Again, I -- that's not my decision to make.
But when we look at it, it's more than the current premium for Plan A.
So the employee only premium for Plan A is eight dollars per minute.
If we were to look at what we see based on the differences in the bids, it's $150 per contract.
So it's a significant difference.
So I have those numbers and I can share and show you what is presented -- what is supported by the financial bees, and we can certainly talk about those numbers.
But we didn't make a formal recommendation on that.
>> CHAIR PROFFITT: If I can jump in.
The -- again, correct me if I'm wrong.
What you're discussing is to make up the entirety of that difference that we have been discussing the last two meetings through rates alone would be what -- that drastically change what Melanie is talking about, the difference between where the bids came in, if there's a member shift over Aetna to 1 percent degree, it's really on the discounts of the Aetna network specifically within the kc metro that drives that disparity between the two bids.
I don't believe what this has is any modelling with assumptions on if there's a 2 percent difference, 2 percent or is it percent, we have to see that experience play out.
What you're saying it would be a monumental task to make up the entirety of that $200 million over the course of five years through rates alone.
If there is a member shift migration from Blue Cross Aetna, and we do realize those discounts that were out there with their network, that's where the savings would come in.
There is no modelling to that effect to see what the -- there's no assumption of membership based on rate increase differential.

>> VICKI SCHMIDT: But Segal should be helping to project how many -- what do you think, how many will would switch Aetna.
I guess -- it's in the recording that you specifically asked if they could get that to us by this meeting, and I went back and looked at the transcript, and you specifically asked if we could have that and they said they model it.
When I ask for it, I'm told they didn't -- I mean, we didn't receive that.
I mean, I -- if it's 1 a50, it's 150.
I think I should have had that information prior to sitting down here today, and that's very disappointing to me that you didn't follow through with what you said you could do it and you said you would provide it before the meeting, and because it was going to take a while, you know, I think that also would have been information that we should have had before we made a decision last time because $150 increase for the others is a lot.
Anyway, I guess.
>> CHAIR PROFFITT: If I could interject quickly.
In full transparency here, we had a call a week and a half or so ago and had this discussion.
I said since it's on the member shift I was just talking about, to the hospital worry about presenting that.
That is on me, not on Segal. I apologize for that.

>> VICKI SCHMIDT: That's okay.
The rest of us our vote is the same as yours, so we didn't get to see that, and I think that, you know, don't promise it if you're not going to deliver it.
Well, I have -- a different question.
>> CHAIR PROFFITT: Commissioner Sutton.

>> BILL SUTTON: Kind of following the same line of thought here, quarterback as I recall, and I've slipped since then so I could be off a little bit.
Even without the membership switch or shift, there was a price difference, and so can we see what the increase would have to be, based on the current split and if there's a shift in membership, then obviously that down the road could change things, but we can't really predict that, I get that, that's fine, but in the initial numbers, even with the existing split, there was a difference between the two premiums, and I -- once everything is figured into it.
The so would it be possible to see what that differential would be as it's reflected in the necessary increases.
>> Give me just a minute.

>> BILL SUTTON: Sure, thank you.
>> Grab this and pull it back up.
Ask I believe the shift you're discussing that affects the differential is -- has to do with the admin fee, right?
Aetna had the sliding admin fee that depends on how many people you have enrolled. That's what really changes that differential from that perspective.
The truth of the matter is, that admin fee is such a small amount of the savings.
The vast majority of the savings is based off of discounts. So the admin fee represents such a small amount, that frankly, we can basically ignore the admin fee when we look at it.
It is such a small portion.
That is the portion that depends on how people shift.
Otherwise the discounts are the discounts.
We expect if people move from Blue Cross Aetna based off of the pricing that we received, we expect that we will see a decrease in the claims based off of the contracts that are in place at Aetna.
The so that -- happens regardless of how many people shift, and that is where the bulk of the savings we would see is.
When I talk about that like 150 -- about 150 million -- $150, not million, too many millions -- I'm so used in talking in millions up here.
When I talk about the $150, that strips out the admin fee completely.
We are just ignoring the admin fee.
If we look at claims, what do we expect the claims difference to be.
There is a slight shift, that's based off of admin as well, it's very difficult to predict how many people are going to shift and we don't -- the last thing you want to do with any plan, five two carriers like this and have this differential, you don't want to get in the game where your projections are dependent on member behavior because we are never going to going to get it exactly right.
Predicting human behavior, if I could do that, I can't.
I won't pretend to.
The so what we want to do, we want to put in place something that semiagnostic to what the member

chooses to do, right.
So that is sort of this 150 is what we would expect to happen with claims alone just based off of discounts with a shift and ignores that sliding scale admin fee.
That answer your question?

>> BILL SUTTON: Sort of.
You're touching on it, yes.
The admin fee is okay.
We can't predict that because that would involve predicting the market, and I get it.
That's fine.
But you said that initially, as things stand, the majority of the savings come in savings and rebates.
>> Discounts.
It's based off of how much Aetna -- the paper that Aetna carries versus blue carries, based off of the reprices we received, based on the providers that your members use, they have some better discounts in place and we would expect a savings if those claims were processed under Aetna versus being processed under blue.
>> BILL SUTTON: Now we are on the topic.   How do those discounts reflect though what the price difference the rate increase for the members would have to be in order to pencil out.
>> So that's where I'm saying it's about $150 per contract.
The so that's not like on an individual, that's like spread across family contracts, individual contracts and so on, right?
So it would really be a very large differential that we would be talking about particularly given the current rates.
Again, with the Plan A rate being at like $80, you could be looking at having to have blue cost as much as twice o as Aetna.
We would have to look at how that works out specifically, but if you were trying to solve for that 150, the differential would be very large.

>> BILL SUTTON: Based on the price predictions that were made in the RFP.
>> Correct.

>> BILL SUTTON: That's where we would see $150 difference between Blue Cross and Aetna equipment think I just got confused.
>> So the -- based off of what was submitted for the RFP, right, so basically we give them all of your claims and they reprice all of the claims, and so when we look at what was reprised, if you reprised all your claims under blue.
>> BILL SUTTON: No, no.
I get that.
And I'll get on that soap box a little bit later.
But when we are talking about be still keeping the split, keeping the split exactly as it is, say there's no shift whatsoever, C there was still a price difference between Aetna and Blue Cross Blue Shield, that's what I want to see reflected in what rate increase would be necessary for each.
>> So -- okay, so basically what that would be is that would be if we took only the members on Aetna and reprised their claims on Blue Cross and reprised their claims on Aetna and determining what is happening with the people choosing Aetna today.

I don't have that analysis, that's not something that was done as part of the RFP.
But generally when you start talking about what you want to input as far as a differential between plans, again, to try to keep you somewhat agnostic to movement between the plans, the idea is you don't -- you don't want to exceed what you would expect the shift to be when members move.
So essentially you don't want to lose more premium than you expect to gain in claims.
So you want the shift to be, you know, reasonable here, because of the current population because of the way things are set going to today where you have the pluck of membership in Blue Cross and today the rates are equivalent, right, so if a differential were put in place today, even if it was a very small differential, we don't expect anybody from Aetna to move to blue, right, they have chosen Aetna with the rates being equivalent if you now offer them a rate that's lower, there's no reasonable reason to choose they would move.
We would still some people move for unknown reasons, this is why we can't predict the human behavior.
>> BILL SUTTON: I'm not asking that.
>> Reasonably you wouldn't see that.
So what you're trying to do is when people move from blue Aetna, you want to incentivize them to move.
Because you expect that if they move, their claims may drop.

>> BILL SUTTON: I don't want to incent anything.
I just want the costs accurately reflected.
>> Yes.
>> It's $150 per member per month.
If you charged $150 per member per month to all of the contracts, in Blue Cross, I mean, we could spread those out differently, but that's the average, that would take care of the dollar differential in the bid.
Based on current enrollment.

>> BILL SUTTON: Current split.
>> JENNIFER FLORY: Aetna would be the same, Blue Cross would be $150 more, that would take care of the differential and even that out.

>> BILL SUTTON: Now, again, it's been a spell since I looked at this, I didn't see -- I saw a difference, obviously, but I didn't see that big of a difference.
Scrap.
>> JENNIFER FLORY: I don't know what you were looking at at the time.
Might have been an employee only rate.
150 represents all plans, all tears and that's what we were able to calculate.
So you're taking that entire differential, divided by the number of contracts, and that's where we get the 150.
Based on enrollment today.

>> CHAIR PROFFITT: That's to cover the entirety of the network.
>> JENNIFER FLORY: To cover the entirety of it.

I think what he's asking is put the discount aside, if it's the administrative cost.
>> BILL SUTTON: The administrative costs they already said that was basically negligible, that didn't really figure in.
What I did see was a difference in cost.
Overall. In the RFP.
It says if we keep the existing split, it's going to cost this much, and with Blue Cross Blue Shield, it will cost this much, it was a number, but it didn't seem to me like it was $150 per contract here.
>> The number discussed was $55 million.
One different between what we are discuss today.
>> BILL SUTTON: That involved 100 percent going with one plan only.

I do remember that one.
>> Because we are averaging it out, it doesn't matter how many people move.
We are saying this is how much it is per contract.
With your current split the same per contract amount applies.

>> BILL SUTTON: Assume no one moves.
Let's just run with that assumption because we can't predict what it will be.
No one moves.

even with the 5,000 to 35,000, whatever that was, enrollment difference, the per person cost was lower on the 5,000 people.

even keeping exactly the same split.
No movement whatsoever.
That's what I wanted to see reflected.
>> When we look at like who is in Aetna and who is in blue, right?
Sorry, there may be differences in costs, but we can't compare what's the average cost of someone on the Aetna plan versus what's the average cost of someone on the blue plan because there are lots going to different factors that may be in play there.
They may have very different risk profiles, say everybody, not saying this is the case, say everybody on the Aetna plan is healthy and young and you try to compare their costs to the blue plan, you're not really comparing the difference in the Aetna versus the blue, there's this muddiness of the population that's sort of baked in there, when we try to compare the difference between these networks the best way to do it is to look at the total cost, what would the total cost be and look at it on an average basis and so that's why the number doesn't really change depending on whether you're looking at the current split or whether you're looking at full migration, if we are looking going to cost per contract that we expect to be a difference, then that per contract expectation is the same regardless of how many people, it's agnostic to the split.
Whether you're talking about the split exactly as it is today or whether you're talking about a full migration, we end at the same per contract estimate as far as what we expect claim savings to be under the two carriers.

>> BILL SUTTON: So the RFP -- the numbers on the RFP meant nothing whatsoever.

>> No.
What I'm trying to say is that -- those numbers on the RFP hold no matter how many people are in going to.   Why that's I'm not giving you a different answer for what's the savings per contract today based off of the current split versus what would the savings per contract be if everybody moved.

>> BILL SUTTON: I'm not talking about anyone moving.
Stop that.
No one moving.
I'm talking about the current split.
>> But that's my point is my answer is the same.
Whether we are talking about movement or not.
Why.
>> JENNIFER FLORY: Let me see if I can get to what your question is, if everybody stays where they are today going to everybody on Blue Cross Blue Shield pays extra,s $150 per contract per month, it equals the savings that we saw from the procurement.
Is that what you're asking, if.
>> BILL SUTTON: That's assuming everyone shifts.
I'm talking about.
>> JENNIFER FLORY: That assumes nobody shifts.
If they paid $150 per more contract on every single plan on every single tier, then you would be agnostic as to whether they stay there.
If they shift over, on average, and don't pay the 150, then they're at the lower cost, then we would be agnostic.
The problem is, there are a few confounding factors here, but I think that's the answer to your question.
How much do we need to increase their contributions so they are 100 percent buying up to keep their Blue Cross plan, but we get the savings from the procurement, that's the $150 per contract per month.
>> BILL SUTTON: I knew I was intelligent.
But I look smarter and smarter every day after this.
My motion last month.
All right.
I'll let it go at that, thank you.
>> JENNIFER FLORY: Did that answer it.
>> BILL SUTTON: I don't think so.
I do not think so.
I -- we saw a price difference with the existing split in the RFP.
If we kept exactly the same setup that we have right now, we saw a price difference.
It wasn't $150.
I'm a thousand percent -- no, I'm not, 100 percent sure of that.
I hate when people say 1,000 percent, I'm absolutely certain it was not $150 per contract.
>> I can tell you it was closer to 100.
The difference between the RFP and what we are discussing today is when you were looking at the RFP we are comparing to the current baseline which does include Aetna claims.
But because you already have those people that are on Aetna, there's no savings from them moving

to Aetna because they are on Aetna.
If we compare what would be full replacement Aetna versus full replacement blue, that gaps get a little bit bigger.
>> BILL SUTTON: Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I'm going to jump in here for a second, I think the problem was we weren't given the 100 or $150.
And so we -- you never said never said dollars difference in premiums or $150 when we were debating the contract.
So now you bring it in after the contract -- after the vote has been taken, I think that's a big difference.
And, you know, I guess I'm still struggling.
You still have the provider discounts that you're not -- you haven't even talked about the provider discounts because Aetna has much -- at least my understanding is Aetna has a much deeper discount on the providers.
So if somebody switches over Aetna, their provider is going to get, I don't know, 10, 15, 20 percent less money in their pocket for seeing the patient, which means less money -- less cost to the plan.
>> Correct.
That's when we talk about the fact that the admin fee is such a small part of the savings, but that's really based off of the discounts, I mean the discounts the provider -- the carriers are paying the providers, the paper they carry.
>> VICKI SCHMIDT: Paper that the carry.
Patient going in to get a treatment and the physician getting paid less.
Ann.
>> It's the contract.
So the contract that Aetna has with the provider is at a lower rate than the contract that blue has with the provider and so that's where we see the majority of the savings.
That is where we see the majority of the savings in the difference between what they're paying the providers.
>> VICKI SCHMIDT: I think that's an important point.
It really -- the admin cost is one thing, but it's really the contracts they have with the providers where they're going to pay them much, much less.
>> Correct.

>> VICKI SCHMIDT: But if the discount savings are dependent going to people moving, is right, I mean, that's -- then you have to make that differential big enough for the incentive for the person to move.
>> There's two pieces to it, right.
The if your intention is to get people to move to achieve that savings, are correct.
The differential has to be big enough for people to make that decision, right?
If the difference isn't big enough, you won't see significant movement.
You have to make it big enough in order to see that movement.
But then the other side of it is, you don't want to make it too large because you don't want to -- you

want the amount that you lose in premium to not be more than the amount you expect to drop claims by, right?
In this case, we are talking about the 150 per contract, that's a pretty high ceiling that we have there, but say that you put in -- say it's $30, right.
That may be enough to get some people to move and when they do move, you're going to lose $30 in premium, right if they move from blue Aetna, a $30 differential, you would lose $30 in premium but would expect to lose far more on the claims cost.
A net positive to the plan.

>> VICKI SCHMIDT: So I'm not an actuary, you guy -- you're both actuaries, right?
What's the recommendation because this is what you get paid $40,000 a month for.
What's your recommendation?

>> When we were looking at it.
We were looking at as a starting point of zero and 15 percent, so saying if you gave the Aetna -- if you gave the Aetna plan a zero -- an increase of zero and you gave Blue Cross an increase of 15, and I'm just going to put a zero in here for now, I don't know what reserve balance we want to target.
If we just target a zero reserve balance here, and we click calculate, this will tell us what is necessary for the employer under the scenario and then I can show you what the difference between the plans are.
>> VICKI SCHMIDT: going to zero and 15, what would you predict the movement to be?
>> I don't have a projection for the movement, but I know at 0 and 15, I don't -- at 0 and 0 I think agnostic to the movement.
At 0 and 15.
>> VICKI SCHMIDT: I don't know how you're using that term.
Can you use a different phrase.
>> Sure.
At 0 and 15, it does not matter to me what the movement is, as far as the financial projections go because I expect the benefit to the plan in the reduction in claims to be more than the loss in premium. So I can -- I don't have to predict it, which is a difficult thing to do, it's difficult to know every population behaves slightly differently.
We want to set it in such a wait that the model doesn't care where they go.
Doesn't adversely affect the plan if a member moves from a Blue Cross plan to Aetna plan.
This differential would accomplish that.

>> VICKI SCHMIDT: I don't want to adversely affect the plan, but I want to -- I want it to affect the plan in a positive way.
>> Two at this level.

>> VICKI SCHMIDT: Okay.
With.
>> JENNIFER FLORY: Can I jump in a minute.
For us to not care where they go, it's the $150, right?
If we don't care at all whether they're on blue or whether they're on Aetna for the cost to be the same, across the entire population, across all plans, across all tiers, it's $150 per month.

We started out looking at it thinking, that's a large sum of money, maybe you could increase over time, I don't know what -- I assume everybody up here -- presume everyone up here could have a different thought on that, you know, how you would want to do that.
If you want 1 a$50 year one, that's the difference.
If we started out and we were modelling zero, so let's say Aetna has no increase in premium year one, it's a 15 percent increase on Blue Cross, which picks up what it would have been across, tell me if I'm wrong here because we've models a lot of scenarios, picks up the increase that's needed across both plans.
If we set Aetna to zero, it created a 15 percent increase for Blue Cross.
If you -- what that equates to is about $28 out of that 150.
So we are at going to out of 150.
If you wanted to do that year over year, you could do that year over year, those are sort going to the things we were modelling as we were thinking through this.

>> VICKI SCHMIDT: I guess, Mr. Chairman, since I've been on this commission, we have done 180-degree turn.
Because what has happened, when I first came on the commission, we got -- the last sheet on every proposal was what the recommendation was from Segal and nine times out of ten the commission just followed it and said yeah, we agree and we went on.
Now we can't get Segal to even make a recommendation to us.
The I think that is nuts.
I think that we need to -- you know, we don't -- I don't think that $150 for every plan -- let's use $100, $100 increase per member per month on employee only and employee plus kids and employee plus spouse plus kids, anyway, I -- we are -- going to amount of are graduated now, and tiered now, we don't just take the per member per month, employee only and take it times 4 if you assume everybody has two kids.
We don't -- we haven't ever done it that way.
So I just -- it's very disappointing.

>> CHAIR PROFFITT: So the 150 per plan per month, I'm hearing that to be if you just spread it and average every single contract you have, that's where you get the number, I did $150 times 35,000 times 12 and I got $63 million per month, which is slightly north of the 55 -- 63 million per year.
It is around the savings identified in the aggregate from the last bid received.
I believe the 150.
The what I'm not hearing them to say increase every single contract by 150.
The if it's blended, just to give a baseline, I can't speak for -- before my time, when I walked into this position, I didn't see recommendations so that it was the baseline for me.
I like having vendors that provide guardrails and say, you're going too far there, bring it back, but to try to get inside the Head of Every Commissioner will be a difficult task.
You can kind such aggregate that out.
I think I stated is the last meeting, I'm not finish favor in pricing this to solve for the entire $55 million per year.
I had a hard time believing that number in the first place, even if I do believe it and grasp onto it, I believe the majority of that discount was had in the kc metro area, so then we are going to be putting

that increase on folks in Western Kansas, southwestern Kansas and other places, it's not an actual choice for members to have that point in time anyway.
By having a choice for tiered, which was the motion, to have a choice should the commission choose, it was not a mandate that we do so, it gives us the flexibility to try to mitigate some of that 55 million spread between the two.
100 percent this way.
So provide some flexibility for us to get to some reasonable level of comfort we are making going to move in the right direction, but still allowing an actual choice for our members, specifically those in areas that might not be seeing the same discounts.
One -- the way I also think about this, I may be completely wrong, is the -- there is a lot of the benefit would come from 1 Hewlett Packard pun, 100 percent Aetna discounts in certain markets.
So our providers is going to be okay with us shifting everybody there and receiving less benefit from the state employees utilizing those services, the plan is choosing to pay less, are we going to lose providers in that network, I don't know.
That's part of my hesitation to do that.
If we need to start asking on the regular basis for this needs to come with a recommendation, we can do that, but try to leave it up to the commission.
You get seven Commissioners, having however many different things plus the different types of plans, difficult to pinpoint a recommendation for every single scenario.
The if we need to make that the standard, we can make that the standard.

>> VICKI SCHMIDT: Mr. Chairman, I do agree with you, I don't believe the 150 thumb either.
We agree on that.
I'm not asking that -- what I'm asking is we -- I'm not an actuary, maybe the rest of you have studied actuarial sciences, I have never done that.
But we are not getting the information we need to make an intelligent decision, it's the same thing that happened last month or whenever that was when we messed with the contracts and things.
You know, I guess that -- I want to hear their recommendations, but what I don't want to happen is that we make a differential and our state employees that live in more remote parts of it state than what I live in, make that change and then they don't have coverage, they don't have people to see and then -- then the next people we're going to hear screaming from the priors because the Aetna contract is based on the fact they'll pay the providers a lot less than what Blue Cross Blue Shield is paying them.
They had to with that bid.
There's no other -- no other way to explain that bid.
I mean, I talked to some providers.

>> CHAIR PROFFITT: The providers -- the money doesn't -- it just doesn't get paid from the carrier to the provider.

>> VICKI SCHMIDT: Don't think you won't hear about that.
>> CHAIR PROFFITT: I do.
I'm not in favor of it.
>> VICKI SCHMIDT: That's a problem.
Also then if the providers won't -- you know, I would submit that many providers contract with many,

many insurance companies, and so they'll -- they will tell their patient, I'm not going to be a provider with this network any longer.
You know, I do contract with the stay with this provider.
And then we have other problems.
So I mean, it's all -- it's just all very -- there's not a lot of good answers for us today to do this.
I'll listen to what other people think.
Before we get too deep into doing the differentials or if we do differentials, whatever -- however that ends up, I do want to talk about GLP-1s.

>> CHAIR PROFFITT: Any other discussion on the mechanics of how this is set up.
Commissioner Dechant.
>> STEVE DECHANT: I would like -- can you go back a page.

I'd like to see that you tossed in the 10 million as a minimum balance, could you just put that in just -- just like to see that.
>> CHAIR PROFFITT: If we can hold off on that.
What I want to accomplish here is understand the Meck its.   Why I want to, Commissioner Schmidt had a question about the scenario modelling.
>> STEVE DECHANT: Go for it.

>> JENNIFER FLORY: Just on mechanics, agree with what you said, when I talk asker when we talk about the 150 and Melanie just clarified the difference, you know, that is the difference between going 1 hub percent with Aetna versus 100 percent with Blue Cross, that's the difference in the savings there.
And that is across everything, so we are not recommending in any way that you that same differential across each.
When we do this scenario, which is keep Aetna flat and increase Blue Cross 15 percent, and that equals $28 across all scenarios, you can see here.
>> It's not a flat dollar increase to each plan and tier, based off of percent increases to the current structure.
It would vary by plan and by tier and so the more expensive plans would have higher increases, the more expensive tiers would have higher increases.

>> JENNIFER FLORY: It's a $12.22 increase for employee only in plan a 72.60.
For employee plus spouse, 38.72.
Employee plus children, $127.12 for family.
And Plan A.
The so it's spread as a percentage across them, but that is what equates to the $28 we were talking about.

>> VICKI SCHMIDT: I have my May 11 book here and my book today.
We had -- I had asked for the -- what was cause for GLP-1s at -- per employee per month these figures are amazing to me.
In March -- May 11, you said that on the third one down, implement a set baseline requirement for all

GLP-1s, use or -- use of bmi of 35 or higher, apply it to initial I will treatment and ongoing therapy, eliminating the 5 percent weight loss contribution care option.
You said that would cause in 2027, that would cost $28.36 per member per month.
And all of a sudden -- I mean, less than a month, it goes down to $19.20 in the information you provided today.
It even gets worse when you talk about initial bmi required for AOM treatment of 35 or higher they had to lose 5 percent reduction from the prior pa.
That went from $46 to $19.20 a month.
That does not make any sense whatsoever.
>> So when we presented these numbers, we had been working with Caremark as we discussed previously, if it has rebate impact, it has to be analyzed by care Mark because we do not have insight into the rebate agreements.
Will so we had posed these questions to Caremark, some time ago, and the responses that you were given at the last meeting are the responses that we had received. Those responses never made sense to us, and we kept pushing to ask for more detail behind those calculations and told them we needed more detail to understand the numbers because we didn't understand where they were coming from or how they were arriving at those numbers.
We did have eventually a meeting with them where we were able to get more information and were able to come to an agreement on a number that made more sense to us, and that we were able to validate.
That's the number that you have today.
That's the reason for the discrepancy, we have been working through some of those issues and getting those estimates for the manufacturer rebate impact that we were unable to calculate ourselves.
>> VICKI SCHMIDT: Well, I don't see how -- I mean, that is too big of a discrepancy, I'm sorry.
Rebates or no rebate.
Lucky for you July 1, rebates are going to be transparent for everybody in Kansas on these plans, so, you know, now we fine with blind -- flying with minders on another month while we wait for that.
We were originally talking millions of dollars that the state is paying out for GLP-1s, what is your current number now?
>> Year to date for 2026, the state -- for the anti-obesity, the state has paid about 2.3 through April.
We estimate that for 2026 that total will be about 8.1 million paid by the state.

>> VICKI SCHMIDT: What happened to the numbers we were seeing like over 15 million, what happened to that?

>> So the -- there was a 15 -- I'd have to see exactly what number.
The total cost across the plan for members and the plan is about 13 million, but I would have to see exactly what 15 million we were referencing there.
>> VICKI SCHMIDT: If it's not the members and the Planning and Sustainability only.
>> Correct.

>> VICKI SCHMIDT: 13 million, okay.

well -- you said we are improving that we are having going to GLP-1s.

>> Correct.
In 2025, the plan spend -- would you rather hear total spend or plan spend.
>> VICKI SCHMIDT: Give me both.
>> The total spend was 19.1 million, plan spend was 11.8 in 2025.
We are projecting in 2026 that the total spend will be about 13.1 with plan spend at about 8.1 million.
And we do see -- if I look at 2025 through April, so time period to time period we do see we have paid about $1 million less in 26 for the same time period over what was paid in 25 for that time period.
So we are seeing that reduction in cost in the claims experience.

>> VICKI SCHMIDT: I guess the frustrating part to me Caremark did not do what we asked them to do, and that is -- I don't know who is in the driver's seat.
I guess the plan isn't in the driver's seat with CVS.
We tell them what to do and they say we're not going to do it that way.
>> CHAIR PROFFITT: I think that's a question for CVS, not for Segal.
Caremark.

Commissioner Dechant, before we move on, or did you.
>> STEVE DECHANT: Nope.

>> VICKI SCHMIDT: I would like to hear from every Commissioner if they feel comfortable -- maybe they don't, but I'd like to hear what you think about paying that much out for GLP-1s, because it's not instituted the way we said it would be instituted, if we change it to the way we said we were going to institute it, Caremark says we will see a dramatic increase in our cost because of the rebate situation.
Here they sit in the room and never told us that when we were discussing it.

I am very confused by this whole situation with GLP-1s.

>> CHAIR PROFFITT: Your question, Commissioner, not trying to speak for you, we do lose Commissioner Hensley in 45 minutes, is your question if a motion was made to eliminate GLP-1 for AOM only, how would the commission react?

>> VICKI SCHMIDT: I'll make that motion.

>> CHAIR PROFFITT: To eliminate GLP-1s.
>> VICKI SCHMIDT: Eliminate coverage for GLP-1s for anti-obesity medication usage.
I would also make -- and I would recommend that we have a night that we exercise our ability to give notice and stop it as soon as possible in this plan year.

>> CHAIR PROFFITT: Motion to eliminate.
>> VICKI SCHMIDT: The reason I would say that, if you went and asked -- I believe that if you went -- I'll wait for discussion.
I probably won't get a second and I'll just talk about it again.

>> CHAIR PROFFITT: Okay.
All right.
Motion would be to eliminate GLP-1 coverage for anti-obesity medication purposes only with no impact to diabetes, certainly to begin in plan year 27 but also as soon as it's practical in plan year 26.
Do we have what that impact would be or no?

>> I don't -- we have that we would estimate the aim pact in 2027 to be 8 million.
The if you turn it off for 2026, like I said, we were estimating at 8.1 million.
The I had I had 2 through April so I can do some math on that to let you know about what per month that would be.
We are looking going to a spend of about $570,000 per month.
Just depending -- I'm not sure what the practicalities there on when that would be turned off, but that would be the savings going forward depending on how many months you were able to.
>> CHAIR PROFFITT: Director Flory.
>> JENNIFER FLORY: We would need to provide employees at least 90 days advance notice of any change in the benefit mid year.
>> CHAIR PROFFITT: I would suspect the save for $2 million in plan year 26.
You've heard the motion, is there a second for discussion?

motion dice on lack of a second.
>> VICKI SCHMIDT: I figured that would happen, that's okay.
I want each one of you then, especially people that represent the state employees, to tell them that you're paying -- each employee is paying somewhere between 20 and $46 a month for a set group of individuals to have this coverage, and I got to tell you, if my employees -- when you phrase it that way to your employees, and I know you guys don't have employees, but when you phrase it that way to your employees, be it's a hard no from them.
The so I just -- we are below water in our ending balance, and GLP-1s are a going to part of why we are below water.
And there's no denying that on any which way, whether we get rebates or don't.
There's no denying that, and I -- you start looking at the increases that we are looking going to for next year, my conscience will not allow me to do that, thank you.

>> CHAIR PROFFITT: Commissioner Dechant, I've had you to the queue for a while.
>> STEVE DECHANT: I would like to follow this up with a little bit if I can.
I was going to look here shortly.
I thought I read the explanation about the impact of GLP-1s, it would cost us more not to have the coverage, and may have been my misreading, we didn't get to that last month.
>> Last month, there was an estimate in the terminate coverage of GLP-1s, the estimate given there was zero dollars.
Caremark at the time was telling us they didn't estimate any savings if the GLP-1s were eliminated, which did not make any sense to us as there's certainly a cost associated with the GLP-1s.
So we were able to eventually get them to agree and to provide data for us to validate that we would expect a savings of about $8.1 million, and that there wasn't some ancillary rebate impact eating

through that savings.
But that may be the confusion, that is what was put on the plan change summary last time was a zero-dollar estimate.

>> STEVE DECHANT: So you, they are projecting if we didn't have the GLP-1 coverage for AOM, got my alphabet soup correct, there would be about an $8 million.
>> Correct.

>> STEVE DECHANT: Thank you.
If it's timely, with I would just like to see what it looks like to set a minimum year ending balance, how it calculates out, no differential in cost to the plan -- to the employee just that just that.
>> CHAIR PROFFITT: For every single year.
>> STEVE DECHANT: Just for 27.
>> Just 27.
I'm happy to relinquish if you want me to.
Either way.
The are.
>> STEVE DECHANT: 15.7.
That's to achieve a achieve a year ending balance, 2027.
Okay.

and then from 28 on, it's to achieve the -- hitting the desired fund balance by the end of -- what is that 2030, okay.

we can play with it some more.
Basically to hit this I 10 million will take 15.7 across the board, employer employee.

>> Correct.
It does target the 10 percent at the end of the 2030.
The one caveat, I don't believe it applies if you target the 2027 balance of 10 million, but it would prevent any -- it would prevent any negative balances in future years if that were relevant in that case if you target the 10 million in 2027 I do not believe that provision does anything, but that provision is in the model as well there to prevent any of the other years from going negative.
>> STEVE DECHANT: 2028 could be a zero balance, we don't know for sure.
>> What it would be, if you look at the projection summary, you can see here you have -- you're at 10 million here and so 2028 would be 24 p and so on.
Until you reach that target in 23.

>> STEVE DECHANT: Thank you.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: Thank you, Mr. Chair.

Just to get back to your point, Commissioner Schmidt.
I actually received a letter from -- they're in a practice together, but there are three experts in obesity medicine, and they had a lot of good information in this letter, but I won't read the whole thing, but just talking about obesity is a chronic, complex and relapsing disease, recognized by the American medical association, it's not simply a matter of will power or lifestyle choices like hypertension, diabetes or asthma, obesity requires long term medical treatment and management.
The and it talks about there's an urgent need for continued obesity treatment access.
Kansas has the 7th highest obesity rate in the United States, and that is looking at bmi above 30, which we know increases a number of diseases, including type 2 diabetes, but it's not merely a short-term expense for the medications, it's really a long-term investment in the health and productivity of Kansas State employees and their families.
And modern antiobesity medications have demonstrated substantial clinical benefits, including significant and sustained weight loss, reduced risk of type II diabetes, improved blood pressure and cholesterol levels, reduction in cardiovascular events and improved mobility, mental health and quality of life.
The and for many these medications are life-changing and medically necessary, discontinuing coverage would create barriers to care, interrupt successful treatment plans, and likely lead to weight regain and worsening health outcomes.
In comparison, like -- so State of Kansas spent $11.85 million on GLP-1 medications in 2025.
Eliminating coverage could result in the loss of approximately 13.56 million in manufacturer rebates.
This has the potential to improve the health of the work force.
I'm like just trying to skim this letter, because it's really long.
There are copies of it, Director Flory brought copies of it with her, if everybody would like to have a copy of the letter.
But I would assert that this could affect recruitment and retention.
I know that a lot of people, when they're looking for benefits, they're looking for GLP-1 coverage.
I understands the point about not putting it on the shoulders of all employees, and so I don't know if it's possible to have a tier where we could offer GLP-1 coverage and people pay more to have their GLP-1s covered, just throwing that out there.
This is not my field of expertise.
So I will leave that to the experts to see if that's a possibility.
But I would just first would like to say that I think this is an important information, there are studies now that are showing to long-term benefits of GLP-1s and reduced costs to employee health plans.
Thank you.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: Just a related comment.
We are a group health insurance policy, and group health insurance basically means that all often pay for the care of a few.
Or the younger pay for the care of the older and not as healthy.
Whether it's GLP-1 or heart disease or cancer or whatever.
We can argue whether we should or shouldn't coverage GLP-1 at all, but I certainly would disagree with a tiered GLP-1 then we might as well tier cancer and heart disease and whatever.
So -- what year are we going to for covering GLP-1 across the board?

As an AOM, is the first year or second year.
>> JENNIFER FLORY: So the health plan has paid for weight loss drugs going back into the early 2000s.

>> STEVE DECHANT: GLP-1s.
>> JENNIFER FLORY: They started hitting the market 2024, I think.
For our plan, we really saw the uptick was in 2024.
2023 is when we started to see the increase.
We really hit the accelerator in 2024, about July of 2024 when we looked at our utilization, it just does a huge roller coaster going straight up.

>> STEVE DECHANT: Basically the last two years, 24 and 25.
>> JENNIFER FLORY: Yes.
>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: I believe Segal themselves said we were not seeing an offset in our other medical treatment from people who are on glp-1s.
The other thing, I find it amazing if a physician wrote that letter they knew about the rebates.
"I mean that is like -- I don't know any physician that talks about rebates.
So I think that's an interesting thing.
I would -- but hearing what has been said now, I would like to propose then to add a $300 copay for a 30-day supply of GLP-1s if it's for AOM and tier it out.
Have the people that have some skin at the game.
I'd make that motion.
>> CHAIR PROFFITT: I've seen a number.
Can you repeat the motion?
>> VICKI SCHMIDT: $300.
Because the last chart that I have, be which I don't know if I can believe or not, at $200 it's $2.31 for every employee to pay for us to coverage GLP-1s.
I'd like to squish that down a little bit more, that would be like would be like 1 per employee per month.

>> CHAIR PROFFITT: The motion is add a $300 copay for 30-day supply of GLP-1s for AOM.
That's the motion.
>> STEVE DECHANT: What is it now?

>> JENNIFER FLORY: Coinsurance, on plan h, pharmacy doesn't have a deductible a on plan h, it would just straight coinsurance, 80/20.
The employee paying 20 percent until they hit their out of pocket max, 35 percent.
Then a Plan C and n, you would have to meet your detectable first.
So the employees pay that out of pocket.
Then on Plan C, they pay 10 percent and on Plan N, they pay 35 percent until they hit out of pocket max.

>> CHAIR PROFFITT: Before we get far into the discussion, the motion was for $300 copay per 30-day supply of GLP-1 for AOMs, is there a second?

>> Can that be models?

>> I always hesitate to do these things on the fly.
I can tell you we are projecting the average cost over a year that a member pays for GLP-1s is $233 a script.
I guess one clarification is your motion is to add a $300 copay in addition to their current or replace.
Replace.
If we were to replace current cost sharing, based off of estimates that we have, I'm looking at looking at $1 million in savings just being the difference between 300 and the 233 that we expect them to pay today times the number of scripts that we would expect.
But would caveat that I just did that now.

>> CHAIR PROFFITT: And the very high level estimate without having run the data and the claims.
>> Correct.
>> CHAIR PROFFITT: $1.4 million savings per year.
>> Correct.
>> CHAIR PROFFITT: With that information, is there a second.
>> I'll second.
>> CHAIR PROFFITT: Second by Commissioner Dechant.
Discussion?

Commissioner Cain.

>> CRISTI CAIN: I would just say I have heard from employees who are on the glp-1s are already going to problems paying the cost.
When you look at that cost, that's a really high amount for like what the pay rates of some employees.
And so I would just say it makes it very difficult for them to access them.

>> CHAIR PROFFITT: On average, I'm hearing $67 per month increase if the current cost is roughly 233 per month, it's about 67 per month.
Can we do that math or no.
>> That's correct.
It will vary since deductible coinsurance, it will vary.
If they're in their deductible, they may see an increase at all, once they hit their coinsurance, different plans will see different impacts, but if I look at it across, again, high level estimate.
If I take total amount that we expect members to pay, it's in line with what we saw in saw 25, I take what we expect total to pay across all scripts, about 233.
You DID see that.
It -- the option was to replace it with a $200 copay because currently the cost is slightly above 200.
The so it's also in line with sort of where that estimate was.

>> JENNIFER FLORY: Can you touch on discounts that might be available in the market.
>> Sure.
I did look this up and I would ask Caremark if they have additional information, this is just me on the websites of these manufacturers, but for Wegovy self pay currently, you're looking at about 349 to 399 depending on dosage.
That is for the pen.
There is different prices for the pill.
I think -- at this point likely the majority of your utilizers are using pens..
The pills range from 149 to 299.
There are some of those have introductory offers, these are the ongoing costs they would expect outside of those introductory offers, Mounjaro pens, 499 for month.
That's the cost they would expect to pay if they did the direct manufacturer programs that are available.
>> CHAIR PROFFITT: Thank you.

further discussion?

all right, seeing none, again, the motion was $300 copay for 30-day dose of GLP-1s for AOMs.
So Commissioner Cain.
>> CRISTI CAIN: No.

>> JENNIFER FLORY: Sorry, is Caremark here.
Here's my question, quarterbacks if we raise the copay to 300, is there an impact on rebates.
>> CHAIR PROFFITT: Introduce yourself for the record.
>> Travis Tate, CVS Caremark, yes, there is.
So that's what I would recommend not voting on it now and let us run an analysis.
The manufacturer contracts allow up to a $200 flat copay, anything above that results in a very rapid decrease in rebates, I believe today it's a full loss.
So I think while they've modeled a savings on that increase in copay, when you factor in the loss of rebates, I think be it will actually cost the state money, it wouldn't save money.
>> CHAIR PROFFITT: A full loss of rebates by going from 200 to 300.
>> They will allow up to a 200-dollar a month copay, but won't allow any higher than that while still paying rebates.
One thing to think through, I don't know this, so I'd have to ask Segal.
When they modeled the hundred dollars copay flat across the board, that would be why it showed a slight cost increase because today you're getting to an average of 233 via deductible and then a coinsurance that -- keeps the average copay below 200.
It's complicated but essentially the manufacturers are fine going to deductibles as long as post the deductible, you could still do a deductible and then do a $200 copay after a deductible, that might model savings better.
>> CHAIR PROFFITT: If you had a conversation with the manufacturers they would be at risk of losing 35,000 contract line of business if they hold that line and not be flexible an $300 deductible.
>> We have, they do not care.

>> CHAIR PROFFITT: Has anybody pulled the trigger on that and said we'll walk.
>> A couple have increased the copay, large who willer sale plan that did 50 percent coinsurance, we had a couple of large state plans that have dropped coverage for them altogether because of cost.
The manufacturers are still seeing increases in utilization.
They are not going to budge on it.

>> CHAIR PROFFITT: I know it's easy for the to say, my expectation is when CVS Caremark sits down at the table with manufacturers, you are push going to as hard as you possibly can to say you are going to get going to done and respond to the customers or you're going to lose a book of business across the entire country.
That's my expect.
>> Good expectation, that is exactly how those conversations go.

>> CHAIR PROFFITT: Okay.
Commissioner Schmidt.
>> VICKI SCHMIDT: Can you name any other drug where the copay affects rebates?
>> No.
This is about the only one that does.
I will say there's a general provision in most contracts that anything above a 50 percent coinsurance doesn't qualify for rebates.
This is the only one where they specific limit it to 200.
>> VICKI SCHMIDT: So I mean, this is ridiculous that a manufacturer holds this amount of leverage over any plan.
Can you tell us some plans that have discontinued coverage for GLP-1s?

>> Off the top of my head, the biggest one I know of, it's public information, is state of Massachusetts.
The their board just voted earlier this year very similar position, very similar discussions around cost, they looked at raising coinsurance, copays, ultimately due to cost, their board voted to drop coverage.
They're a fairly large plan, about 1 1/2 times the size of the State of Kansas right now.

>> VICKI SCHMIDT: Thank you.

Mr. Chairman, I will withdraw my motion.
And I will make it for the $200 copay since the manufacturer seems to have us in every which way, whichever way we want to move the rebates are going to.
I would move to do the $200 per 30-day supply of GLP-1s for AOMs, and then I cannot wait for July 1 to start seeing some of these rebate agreements.

>> CHAIR PROFFITT: Is there a please.
You heard the motion.
Is there a second?
Notion dies on lack of second.
Question for you.   I think I heard you to say there is a way to get there by having a co, is there a way we can model out, still realizing the same higher cost share for employees that are utilizing this, which

I think was the intent of the copay motion.
Is there a way to get where the employees are having higher cost share but
>> The way to do it would be detectable plus -- my recommendation would be a flat copay of 200 because then you're ensuring you get to the full 200 every month.
Coinsurance, it's going to vary depending on cost of the drug and so you could -- there are scenarios where you result in a copay above that and that would get pulled out.
>> CHAIR PROFFITT: What I suspect -- because it costs money if we go to 200 because we are above 200 net, so that doesn't help.
>> That's where my question for Segal is did they model a flat 200 copay without the deductible or then the deductible and --
>> It was modeled by Caremark, it is a replacement.
$200 copay and replacement, no deductible, no coinsurance, full replacement.
Ask I think what you're suggesting is to say that instead of doing deductible coinsurance like the plan is today, that the -- you would do deductible plus $200 copay.
So then every month they would pay a $200 copay in addition to the deductible.
I don't know off the top of my head whether or not -- where that lands, like I'd have to look at what that -- what the coinsurances are applying to, it's going to vary some by plan.
I'm not sure.
That would be more modelling, but I believe that's the difference between what you're seeing on the screen and what is being suggested.
>> CHAIR PROFFITT: A coinsurance plus $200 copay on top.
>> Deductible plus the copay.
Replacing the coinsurance with a copay.
Deductible plus copay.
So that you're maximizing the $200 copay.
We would need to look at how that actually plays out.
I'm not certain.
>> CHAIR PROFFITT: Director Flory, you had a comment.
>> JENNIFER FLORY: Yes, just to clarify, Plan A members do not pay a deductible on pharmacy, that that's one of the options you can used.
Plan C, j and n do have to meet their deductibles before their prescription drugs are eligible for payment by the plan.
And after that, then currently they would because this is a planned, they would be paying 35 percent.
35 percent of the cost of that, that's they're playing today.
Plan A members start from day one with one pharmacy, they're paying the 35 percent coinsurance.
Yeah.
Once they meet their out of pocket, then the plan picks it up at 100 percent.
On all plans.

>> Just a comment.
I've made a note to myself in regard to GLP-1s to do whatever the most financially beneficial to the plan.
There are more moving parts here than I can keep track of.
I really don't -- until it says that the cost would go up with what you first said, and I don't know -- I think the costs -- our costs would probably still go up or be no better with 200.

We haven't got enough time today to be able to make a change to what we've been without either we drop it totally or we risk costing more than what it does right now.
I agree, we need to somehow figure it out, I think we need to let this thing ride out the rest of the year and potentially into 27, but yes, it's a crazy system.
It's terrible, but we are over going to barrel if we want to cover this at all for people.
And I'm not sure that we have got the data, if we don't, we need to get it and employing it to assess are we seeing some improvements in health outcomes after a year and a half, two years or so of actively covering GLP-1s.

>> CHAIR PROFFITT: Yeah.
I'll comment.
I wholly concur, Commissioner Schmidt.
I think the manufacturers have entirely too much power, I think, collectively, not we as a commission, the country is allowing that to happen.
With candidly, I need more help from CVS Caremark.
I need you guys to be a player.
I know you're pushing, we need to push until such time we get them to bend and break and give the discounts that are available going to should be here and not held hostage for plans across the country, I need you to keep pushing, once a week, twice a week, I need more rigor around this.
I need Segal and Caremark to sit down and make sure that we iron out these differences ahead of time and not go weeks in between.
If I need to carve out an hour every single week, I'll do that.
Better data sharing, better information, better transparency and somebody sitting at the table fighting every day for the State of Kansas, we got to get a handle on this.
It's runaway right now.
>> Understood and agreed.

>> VICKI SCHMIDT: We did have this conversation a year ago and we decided to instruct CVS to do something, and that -- that's disappointing to say the least, but, you know, I have to agree with him, I mean, they are not going to budge, their business model is making tons and tons and tons, millions, hundreds of millions of dollars off of this one class of drugs, this is one class of drugs among all the other drugs, think about all the specialty drugs, all of that, every drug on the market, which I don't know how many drugs are on the going to right now, I don't keep up with that anymore, but, you know, millions of drugs, this is one drug that does this.
I'm telling, they are not going to change it.
They're not going to change it.
They have a business model working so well for them.
And back to the physicians letter, did they talk about the complications of GLP-1s.
The ones where your gut doesn't move anymore, where you can't have a bm because there's no mobility and -- in the gut, there are severe complications from the use of GLP-1s.
Everybody doesn't do just great on them.
There's depression, there's -- there's a number of side effects.
I would love to do a presentation before you about the side effects and with the people that the people who have had trouble with them.
It's not a, man, I'm going to go on GLP-1s, and this is going to work.

And there is no reason in my opinion for the State Employee Health Plan, when somebody has a bmi of 35 or 37 or 38, I agree.
When they get down into the 28s or the 25s and we are paying for them to -- that is just absolutely ridiculous.
That is just -- I cannot do that.
I cannot do that -- I cannot do that to this fund and I cannot do that to the state employees that are picking up the slack.
Because one thing that hasn't been said about this is remember, we going to --
I think GLP-1.
>> I had the same thoughts.

>> VICKI SCHMIDT: Perfect timing, thank you.

the one thing that hasn't been mentioned is remember, very the legislature gave the state employees a 1 percent raise.
The 1 percent raise.
Remember that when we start talking about increasing these rates on state employees, thank you.
I'll try to shut up about GLP-1s, but I'm very passionate about this because I cannot see robbing this plan -- I mean, we were going along just fine -- not just fine maybe, but our head was above water before GLP-1s, and after 2024, we have hit the -- we've hit the ditch and gone below the gutter, thank you.

>> CHAIR PROFFITT: This hearing is going over anyway to develop a plan that shows some sort of cost share agreement that is an increased cost share for the employees and shows a net share savings to the plan before our next meeting in August.
All right.
I think it's time we move to the I.R.S. required change in the plan.
If we can go there, make a change.
In all seriousness, I do appreciate the discussion, which is I think everybody is very engaged in this and trying to do right by our employees, whatever that means.
One thing -- this will be my final comment on the GLP-1 discussion.
Nobody here is doing it.
I want to make sure we are not stigmatizing for whatever reason, it's a choice of folks if it's available to them.
I think about that sometimes when we talk about different policy areas across the state.

Pete, if we can.
Jennifer?
Almost there.
Back to where we are going, trying to get the ball moving.

appreciate it.
Let's start with the I.R.S. required one, on row 267.   Why are I.R.S. requiring an increase from 3400 to 3500.

Are deductible in Plan C.
The if you can move that to yes please.
>> Want to change the family tier per line 27 or just line 26.

>> Member plus is a change.
Both required 3500.
>> CHAIR PROFFITT: Whatever is required, let's move those.

>> JENNIFER FLORY: Line 26 is the required change, keeps the family deductible at the same amount.
Line 27 is a possibility, increases the overall family deductible to $5,700, which is a $200 increase.
We wanted to show you a different option.
That's what he's asking.
The what you're saying you want line 26.

>> CHAIR PROFFITT: That is what I said.
We have a motion to say yes to line 26 alone.
Is there a second?
Second by Commissioner Cain.
Cane discussion?
I think we need to do it on n as well.
26 and 34.
If that's okay with the maker of the motion.
Commissioner Schmidt?
Commissioner?
Is it okay to make the motion to do line 34 because it's required by the I.R.S.
>> They're required for high deductible plans.
Yeah, okay.

>> CHAIR PROFFITT: All right.
We have a motion and second by Commissioner Cain, any discussion?

all righty.
>> CRISTI CAIN: Aye.

>> STEVE DECHANT: Aye.
>> ANTHONY HENSLEY: Might have lost him.
Commissioner Sutton is aye.
>> VICKI SCHMIDT: Aye .
>> CHAIR PROFFITT: Motion carries, we have made those changes.

going back to director Flory going to discussing on eliminating the special case pharmacy tier, item that originated 20-some odd years ago and is confusing and providing little benefit, is there any particular feeling one way or another, another, 1 net save for the plan committee does that remain the

coinsurance remains 40 percent?

>> JENNIFER FLORY: It would eliminate that tier.
Those drugs would just become the standard coinsurance, which would be on a brand 35 percent.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Feel strongly about that want to make a motion.

>> STEVE DECHANT: Does that mean some folks would see a reduction in their pharmacy costs, correct.
>> JENNIFER FLORY: It's possible.
Because that was capped at $100, it's a potential they might see a slight increase, but there aren't many drugs on that list, there aren't a lot of claims, that's where there's not a lot of savings, just not a lot of impact there.

>> CHAIR PROFFITT: Commissioner Sutton.
>> BILL SUTTON: Thank you, Mr. Chair.
Jennifer, you mentioned these drugs haven't been updated in a long time.
What sort of thing are we talking about here?

>> JENNIFER FLORY: Back when we originally put this in place is when the plan went originally from having copays to coinsurance.
There was a concern that if you just applied a flat coinsurance that -- back in the year 2000 our employees would not be able to afford those medications and so this was put into place and it was looking at a cost -- a drug that cost at least $500 or more, the average dispensing for the average patient would have been about $500 and we were just capping the potential impact to an employee because we were concerned that they wouldn't be able to afford those.
But now there are tons of drugs that cost $500.
So the drugs on this list are fairly old, probably most of them are significantly lower cost today.
I don't know when the last time it was updated was, but I would easily guess it's been 8 to 10 years ago, we have not added anything, because it's before Paul.
This is just a really old list of drugs.

>> BILL SUTTON: I'm old.
>> JENNIFER FLORY: Even the wording, because it's called special case, people get that confused with now we have so many specialty drugs, back when this was put in place, that wasn't the case and it was seen as a Safety Net.
It's really not a Safety Net anymore.
We have so many drugs that are over going to $500 mark that are not included in that benefit.
>> BILL SUTTON: That was going to be my follow up.
I'm glad you brought that up.
Who would have been responsible for adding every drug that's over $500 to that list?

>> JENNIFER FLORY: It was generally done based upon inquiry.
So you had a member who would reach out and say, I can't afford my drug, we would do research internally, we worked with Caremark and I find out how much the average spend was.
We looked at it from not just the members that -- that individual member who came forward, but also asked Caremark what is the dosage, dispensing cost for that medication and if either one was over $500, then it could be added to the list for that -- either that individual member, the individual member's need was more than $500 or if the average cost was over $500, then we added it for everybody.
It was really one off.
Like I said, this is very, very old, it's something that we haven't been involved with updating because so many drugs today are over $500.
And we have a specialty class now.

>> BILL SUTTON: There we go.
There we go, that was going to be my question, we didn't have any inquiries during all this time.
>> JENNIFER FLORY: I don't know, Paul, not specific to this benefit.
They probably had inquiries about costs of drugs, but they weren't things that necessarily got added to this list.
So it's just kind of dwindled down to I think it's about a page.
Less than a page.
Not even the full page of a list of drugs.
So it's gotten minimal impact but would make our plan cleaner to explain to members when they wouldn't get tripped up why is this special case and why is the specialty, what's the difference?
It outlived its usefulness.
>> BILL SUTTON: We have a new category that catches those.
>> JENNIFER FLORY: Yes.

>> BILL SUTTON: Very good, thank you.

>> CHAIR PROFFITT: Having not seen a motion, we can move on.
If somebody wants to come back at it, we can do that at a later point in time.
Any other.
>> STEVE DECHANT: I move that we, per recommendation from the director, eliminate that special case pharmacy tier.
And just leave it at 40 percent -- no, roll it into what exists already.

>> CHAIR PROFFITT: You've heard the motion.
Is there a second.
>> CRISTI CAIN: Second.
>> CHAIR PROFFITT: Further discussion?

hearing none.
>> CRISTI CAIN: Aye.

>> STEVE DECHANT: Aye.
>> BILL SUTTON: Aye.
>> VICKI SCHMIDT: Aye.

>> CHAIR PROFFITT: Motion carries, 4-0.
Thank you.
The
any other items on this change tab that any Commissioners had interest in or wanted to review or discuss?

Commissioner Schmidt.
>> VICKI SCHMIDT: I did not ask for this to be modeled so I don't think it's up there, but our specialty, I could look back in the information, but did we go from a $50 copay to a $60 for specialists we're at 60 right now.

>> CHAIR PROFFITT: Yeah.

>> We changed that from 40 to 60 last year.
On specialists copay, that's what you're talking about.
>> VICKI SCHMIDT: Yeah.

what was that.
>> The bcp is still at 20.

>> VICKI SCHMIDT: Right, right.
I would make a motion to make the specialty drugs -- no, no, specialist $50 instead of 60.
I think we -- I think that $20 effort from more than one person that $20 jump was a big jump, and, you know, I personally believe that more and more primary care internal medicine family practice people refer people on more than they used to, and if you're paying $60 every time you get referred to a specialist, I think that builds up because that's every visit.
So I would like to at least see us go down to $50 not back to 40, but $50, and I did not ask it to be modeled, I'm sorry.
I'm sorry.

>> CHAIR PROFFITT: So that was a motion.
Do we have a second?
To go from 60 to 50.
>> CRISTI CAIN: I'll second.
>> CHAIR PROFFITT: Discussion?

>> STEVE DECHANT: That's not on this list at all, we don't know the financial impact?

>> JENNIFER FLORY:

>> VICKI SCHMIDT: Mr. Chair, can we look back and see what it was when we went from 40 to 60 and divide it by 2?

there it is.

>> VICKI SCHMIDT: Okay, okay.

okay.

500,000.

okay, okay.
So half a million dollars, thank you.

>> CHAIR PROFFITT: Can you scroll down, Pete.
Right there.
Right there.
The
so far the changes we made in 27 is $135,000 to the good.
So it would be approximately 370 to the bad with this change, before we do anything else.
Just aggregate.
Further discussion?

>> STEVE DECHANT: Have a hard time thinking that any cost of the plan before we have resolved where we're going to seek to end up bottom line projected end of 2027.
As I recall -- what's our latest now show about $15 million deficit at the end of the 27 if there's no changes.
I'm reluctant to talk about anything that will increase our deficit or being in the hole before we address where we are looking going to.

>> CHAIR PROFFITT: Thank you.
Scroll back up, Commissioner Schmidt, do you have a comment.
>> VICKI SCHMIDT: I gave you an opportunity to decrease it dramatically, and nobody -- I couldn't even get a second.
So I don't really want to hear that.

>> CHAIR PROFFITT: Everybody can have a comment.

no further discussion, Commissioner Cain.
>> CRISTI CAIN: Aye.
>> STEVE DECHANT: Nay.
>> BILL SUTTON:

>> VICKI SCHMIDT: Aye.
>> CHAIR PROFFITT: Motion fails.

sorry.
Vote was 2-2.
Push it to 3-1.
We need 4 votes either way.
It requires 4 votes.
>> VICKI SCHMIDT: Where are our people that are supposed going to sitting in these chairs.
>> CHAIR PROFFITT: As I mentioned Commissioner Hensley had to leave at 11:30.

all right.
Any other changes on this tab that anybody would like to see.

>> STEVE DECHANT: I was the one that submitted the changes for I think it was 10 percent, 15 percent increase for employees or employers, and also a adoption of out of pocket.
As well as deductible.
Are and my attempt was to bring us out of it hole in 2027.
Under the old numbers, I think that got us back to about 6 million, which is woefully short.
We could be wiped out in no time at all.
But at least it kept us out of it hole and left us with a projected positive amount at the end of 27.
So I'd suggest we -- that's biting off the whole thing, of course a part of that funding comes from the 15 percent employer and 10 percent employee increase in rates.

which wasn't too far from something we had modeled I think -- when the 10 million was put in.
I think that came up with a 15 percent across the board if I recall.
Anyway, that was my proposal, almost a month ago now, and you saw those if you looked at it, what kind of impacts those have across the board and what the bottom line is, if all of that was put into place.

my thinking is, I think we failed to -- we had balances that weren't getting small, but I think over the last few years in our efforts to balance some things out from 6 to 8 years ago we let things tip, this year some things happen and wipes out what we have.
I don't think we can ignore that.
We may be able, through the course of a fiscal year, go into the negative, but if I understood the Chairman correctly, at the end of the fiscal year, we darn well better at least be at one dollar above even with the board.
Our projections have to do with end of calendar year.
Who knows what will happen.
I'm not comfortable with the -- I'm not comfortable at all with the as picture of projecting about a 6 or $7 million balance at the end of the 2027.
If the same thing were to occur in 2027 as what's occurred the first year or of this year, we have already gone under water.
So anyway, that's the thinking I had when I put the whole package together.

>> CHAIR PROFFITT: Commissioner Schmidt.
>> VICKI SCHMIDT: Did your modelling include a tiered approach in the two plans.
>> STEVE DECHANT: No, before we even talked about that.
Does not include that at all, simply across the boards.
>> VICKI SCHMIDT: I think we have to do a tiered plan, I think the tiered plan because of what we learned last time we voted -- when we voted on that, and I -- I think that was your suggestion, Mr. Chairman, and I think that we have to do a tiered plan going forward.

>> CHAIR PROFFITT: Any other thoughts or anybody interested in any of the changes listed on this tab, some with increasing out of pocket max, some with increasing deductibles, scroll through.
I don't remember the other ones.

>> JENNIFER FLORY: You might want to look at adding the on Plan A if you're interested in having members have to pay part of their GLP-1s at the beginning of the year, which is, line 18.
If that interests you at all.
S with

>> CHAIR PROFFITT: Walk us through that change.
>> JENNIFER FLORY: What that says is today a person who goes in and buys a prescription drug on January 1 only pays their coinsurance, if they go to the doctor, they have to pay their deductible, this applies the same deductible amount across both the medical and the pharmacy.
There isn't a huge impact just because so many people Plan A members tend to meet their deductible over 10,000 of them do, where versus Plan C and n, where the number who meet the deductible is very, very small.
>> CHAIR PROFFITT: The impact is on the pharmacy side.
>> JENNIFER FLORY: Right.
>> CHAIR PROFFITT: This would apply to GLP-1s as well.

>> JENNIFER FLORY: To all pharmacy.
>> CHAIR PROFFITT: Looking at CVS Caremark, have any impact on rebates to apply deductible on plan with an to -- the answer was no impact to rebate, is that correct?
That's on the record.

>> Yeah.

>> CHAIR PROFFITT: Any interest in that, commission?

Commissioner Cain.
>> CRISTI CAIN: I just had a question about it.
So on January 1, when a person goes to pick up their prescription, they're paying the full cost of that prescription until they meet their deductible, is that accurate?

>> JENNIFER FLORY: Yes, the full discounted, whatever Caremark's discount on that drug, just like c and n.
They go to the pharmacy on January 1 and whatever the discounted price is.
It just would make it similar to what you see on Plan C, j and n.

>> CRISTI CAIN: Thank you.

>> STEVE DECHANT: My requested change didn't include that particular one, did it.
With I think mine were all on the medical side.
>> Yes, sir, that wasn't on that one.

>> STEVE DECHANT: Okay.

>> CHAIR PROFFITT: Not seeing much interest there.
>> STEVE DECHANT: I would make that motion, where are we there?

>> CHAIR PROFFITT: 58.
>> To go ahead and apply the deductible to both medical and pharmacy.

>> CHAIR PROFFITT: Motion, is there a second.
Second Commissioner Sutton.
Any further discussion?

seeing none.
>> CRISTI CAIN: Nay.
>> CHAIR PROFFITT: Commissioner Dechant.
>> STEVE DECHANT: Aye.

>> BILL SUTTON:
>> VICKI SCHMIDT:

>> CHAIR PROFFITT: Okay.
Right now we are -- going to.
2-2 vote.
Chair's vote will not alter the outcome.
Motion fails.

any other changes on this page before we move to changes, Commissioner Dechant, did you want to make a group motion to include this page.
>> STEVE DECHANT: I make a motion that -- well, go from there.
That we increase the employee rate increase by 10 percent and employer rate increase by 15 percent and that we increase across the board -- I don't know exactly which lines, help me out, Pete, the an a, c and n deductibles and the Plan A, c -- excuse me, and the plan -- the out of pocket expenses for all plans.

if I captured in words what I asked -- that was the plan changes that we all got back from Pete and Jennifer about three weeks or so ago.

and again, as it was then, I think it resulted in a 2027 fund balance projected of some place in the neighborhood of $6 million.
Versus the 15 million that's -- with no changes currently projected to exist.

>> JENNIFER FLORY: Commissioner, from your e-mail, he picked on Plan A to increase the deductible to 1250, 2500?
On Plan C and n, the deductible would be 3450/5700.
Which I think would now be line 27 if you agree because we had to increase the deductible to 3500 based on the I.R.S., so I think you're asking for line 27, is that correct?

>> STEVE DECHANT: Yes.

>> JENNIFER FLORY: Okay.
The single deductible to 2900, we have that on there.
Yes, it's line 31.
And then he's layering in the out of pocket on Plan A at a hundred/11,000.

Plan A the out of pocket would increase to increase 5500, 11,000.

Plan C, the out of pocket would go to go to/9500.

Plan N, the out of pocket goes to 6900/1380.

and Plan J, the out of pocket goes to 7600/1520.
I didn't see it -- oh, yeah.
We are clarifying on Plan J because remember this plan was designed to meet the requirements of those that carry certain Visas, we can't increase the deductible because that's a requirement for the Visa to stay at that level.
On Plan J, it was only a deductible change to meet that requirement, and that is what was on the list we received.

>> CHAIR PROFFITT: All those changes on this tab plus increasing the employer contribution by 15 percent and employee by 10 percent, that's what I heard you say, Commissioner.
>> STEVE DECHANT: Correct.
>> CHAIR PROFFITT: For both Blue Cross and Aetna, is that the same?

>> STEVE DECHANT: Yes, the tiered thing wasn't in the mix.

>> CHAIR PROFFITT: That was your motion.
>> JENNIFER FLORY: 15 percent from the employer and 10 percent from the employee just to clarify.

>> STEVE DECHANT: Correct.

>> JENNIFER FLORY: Thank you.

>> CHAIR PROFFITT: A minimum of any balance in 27.
>> STEVE DECHANT: No, take that off.

correct.

>> CHAIR PROFFITT: 10 percent across the board.

all right, recapping, this motion and correct me if I'm wrong, Commissioner, would be allowing a negative balance, mow minimum balance in 27, increasing employer contribution by 15 percent, increasing employee contribution by 10 percent for both carriers, plus all the plan design changes that we saw on the other page, increasing the deductibles and the out of pocket max across the plans.
Everything.
Is there a.
>> STEVE DECHANT: With the negative balance, right?

>> CHAIR PROFFITT: There was no --

>> STEVE DECHANT: Calculate, that should life us with a positive balance at the end of the 27.

>> CHAIR PROFFITT: We'll run the model and ask for a second.

>> Showing 5 toy 2ish for next year.

>> CHAIR PROFFITT: For 27, ending balance.

and then can you go to the pemp tab, please.
The very first tab.

>> Your employee rates would be.
>> CHAIR PROFFITT: Scroll down to the right if you would so we can see the Delta.
Doesn't show.
Got you, yeah.
I'm sorry.
I was on the wrong page.
Scroll back.

>> STEVE DECHANT: Why doesn't it show the Delta.
>> CHAIR PROFFITT: If we do the tiered pricing.
We could calculate the Delta.

Current plan 81.40 for employee only on row 26.
89.54 for Plan A.

>> STEVE DECHANT: Got you.
Yes, I see it, thank you.

>> CHAIR PROFFITT: That is the motion.
Is there a second?
Okay.

>> STEVE DECHANT: Would be very open to -- depending on the Commissioners, if a tiered is desired, what I'd like to see us do is Tinker with the tier with while leaving these others and seeing how they modify or what might happen.
>> CHAIR PROFFITT: Like to amend your motion?

>> STEVE DECHANT: I don't have a tier in mind.
I mean, an amount.
I would be open to somebody suggesting something, I'll be glad to incorporate that.

>> CHAIR PROFFITT: Commissioner Sutton.

>> BILL SUTTON: Based on the discussion we kind of had back and forth, I'm not exactly sure what that tier would look like in order to even out.
Obviously $150 is nuts, but I'm not sure what that tier would look like if I could get some guidance on that, that would be great.

that's a legislative term.

about 10 percent Blue Cross and 0 percent Aetna.
Na wasn't that close to something you said earlier, Melanie.

>> Averaged across all plans and all tiers, somewhat less than that.
If it's still in here, I believe there's a tab I could tell you exactly what it is when we do it.

>> VICKI SCHMIDT: Can you substitute a motion for his own motion?

>> CHAIR PROFFITT: He can amend his motion prior to the second.

>> VICKI SCHMIDT: I wanted to say welcome to the club.

>> CHAIR PROFFITT: Go to the big dollar tab first.

>> 4.2.

sorry, 0 intent.
>> STEVE DECHANT: That was the only change made, is that what you did.
>> CHAIR PROFFITT: Go to the rates.
Scroll down to the right, that's where he showed the difference between the two.
Aetna, the column effectively today since we raised it by 0.
That it's today's.
Those choosing Blue Cross.

is there a second?

discussion?

>> STEVE DECHANT: That isn't exactly what I had in mind.
It was going to be above and beyond or on top of what I had already proposed.
>> 10 and percent on Aetna and an additional 10 percent on Blue Cross.

>> STEVE DECHANT: No.
What I thought the chair was suggesting is we layer on top of what I -- what you had up there a tiered Blue Cross/Aetna.
I wasn't suggesting to do this only.

>> So then you're saying make sure I understands it.
10 percent.
>> STEVE DECHANT: I would knock it down to 5 percent Blue Cross, again, layer on top of what I had.
>> That would look then like this, with the 10 and with the 5 percent Delta between the two of those.
>> CHAIR PROFFITT: We didn't change anything about the other tab.
About the plan design changes.
We did on your initial motion we heard it was 2 percent.

>> STEVE DECHANT: So the plan design changes were wiped out.
>> Your plan design changes I left in, sir.
Those are all going to.
The only difference was just what are we doing for a rate increase.
For percentage increase in addition to those plan design changes.
>> STEVE DECHANT: Then the 10 and 15.

>> CHAIR PROFFITT: Make sure it's okay with the second. I want to make sure the change is okay with the second before we do discussion.
>> STEVE DECHANT: Go back to contribution levels.
>> One second, sir.

>> STEVE DECHANT: I thought we were going to 10 and 15.

>> 15 percent for plus cross and 10 percent are necessary going to a 5 percent Delta between the two.

>> CHAIR PROFFITT: Percentage point.

>> CHAIR PROFFITT: This retains all the plan design changes from the original motion and under the amended motion, 10 percent increase in Aetna pricing, employee contribution and 15 percent increase in Blue Cross Blue Shield.
This is what the new pempm's would be.
The

>> STEVE DECHANT: If -- thank you.
The
if you could walk me through that just a little bit when we go with the -- never mind, never mind.
I got it figured out in my head, thank you.

that answered my question, thank you very much.

>> CHAIR PROFFITT: Change to the motion okay with the seconder?

okay.
Discussion, Commissioner Schmidt.
>> VICKI SCHMIDT: Well, I do not support the plan changes, to me that's just nickel and diming us again.
I also don't support -- why are we raising the rates on the plan that's saving us money, why would we increase to rates on the Aetna plan when they're saving us money.
And I also think that the Delta ought to be larger.
I mean, I'm not going to make a substitute motion, but I'm just going to vote no on this one and hope I get at least one other no.
I think that the actuaries originally modeled 0 and 15 percent, and I think that 15 percent Delta is -- I just love using that word.
That Delta, I'm not agnostic about it.

mine are much smaller than yours.
Anyway.

So I'll be voting no on this motion, thank you.

>> CHAIR PROFFITT: Commissioner Cain.
>> CRISTI CAIN: I would like to see the projection summary, please.
Of.
>> STEVE DECHANT: Would you go back up to where it shows the percentage increase to employer and employee.
Yes.
Thank you.

>> CHAIR PROFFITT: If I have to vote, I will be voting no.
I don't want to do 50/50 split between state and employer.
We have done really good over the last couple of years about restabilizing this plan, but it's my -- remind the commission from, 2018, 2019.
They saw 6.4 percent increase, followed by 9 percent increase, followed by 7.7 percent, followed by 3.3 increase, employee contribution, there were no pay raises any of those years, employee spouse and children, children .7, 30.4 percent increase, 31.8 increase, those are stacking, followed by 16.7 increase, again, largely no pay increases, we are in a spot where, as Commissioner Schmidt mentioned earlier, only a 1 percent increase for state employee pay this year, in my estimation, I think the state owes either a pay increase or holding the line better on benefits.
As I mentioned last time, somebody was making 30,000 a year, $300 increase pretax.
That gets wiped out with this.
I would also vote no for the fact we are going to the employees and employer to do the same when the employer did not do as much for the employees they should have on the front side.
Personal opinion.

I can't get there on this.
>> STEVE DECHANT: Was not expecting an even employer.
>> CHAIR PROFFITT: That's part of the motion.
>> STEVE DECHANT: Okay.

the numbers, I'll certainly enjoy myself.
First off, I do want to say going back to appropriations, which is kind of why I'm here saying that there's a 15 percent employer increase, due to the fact that we didn't save $50 million a year, is going to be a tough act.
It's going to be a tough argument to support that.
But reality is reality, we got to deal with that.

>> But let's look at as far as the employee rate change, ending with $9 million, yeah, that's great, but then 28, 29, 29 really gets excessive.
I think we would be adjusting it back down after that.
Let's look at a more moderate change, we had one that was like 4.2 million in reserve, I think that was

at the 10 and 0, I believe.
36.
>> VICKI SCHMIDT: The motion on the table, though.
>> I'm playing with the motion.

>> VICKI SCHMIDT: Make a substitute motion.

>> You are correct, Commissioner, that would be in order.
Let me go ahead and substitute 10 and 0 in that, and I want to look at the projections summary before I seek a second on my proposed change.
>> CHAIR PROFFITT: Substitute motion leave all plan design changes intact, leave the employer contribution at 15 percent and modify the employee increase to 10 percent for Blue Cross and 0 percent for Aetna, is that the motion.
>> That is the motion.
>> CHAIR PROFFITT: Hit run so we can have an educated potential second.

>> Yeah, 4.2.

>> CHAIR PROFFITT: First tab, please.

>> Yes, that is my motion.
>> CHAIR PROFFITT: There is a substitution motion.
Is there a second?

>> CHAIR PROFFITT: Hearing none, the substitute fails.
Pete, if you can make that change 15 and 10.

>> VICKI SCHMIDT: Call the question.
>> CHAIR PROFFITT: Question has been called.
As soon as that gets done running.

Commissioner Cain.

>> CRISTI CAIN: I'm not familiar with that so I'm going to abstain.
>> CHAIR PROFFITT: With calling the question.
It just means we end debate and vote on it readily.
>> CRISTI CAIN: I vote no.
>> STEVE DECHANT: Aye.
>> BILL SUTTON:

>> VICKI SCHMIDT: No.

>> CHAIR PROFFITT: Motion fails.

who else would we like to see, reset the plan design, those change back to where they were.
Let that calculate in the plan design.

Commissioner Sutton, could you take over for 3 minutes as chair, that would be helpful.

>> BILL SUTTON: We'll wait.
>> CHAIR PROFFITT: Call a 5 minute recess.

we are in recess for 5 minutes.

>> CHAIR PROFFITT: All right, we are -- going to regather and grab our seats after we fill up here and back going in about 30 seconds.

minute takers, we should be good.
We have counsel and Commissioners.
So all right, Pete, are we back on?
Commissioner Schmidt.
>> VICKI SCHMIDT: I have a motion to just get us started here.
Not get us started, we are already started.
One to try.
I would like to do a tiered of 0 percent on Aetna, 15 percent across the board on Blue Cross Blue Shield, I'd like to see what that number looks like to see what my third part might be.

>> CHAIR PROFFITT: No plan design changes.
>> VICKI SCHMIDT: No plan changes.

>> CHAIR PROFFITT: Pete, run that, please.

>> CHAIR PROFFITT: Can you show The Big Picture financials first.

>> VICKI SCHMIDT: What does that give us on ending balance.
>> CHAIR PROFFITT: Negative 12.
>> VICKI SCHMIDT: Okay.
So what would we have to do on the state side, can you plug in like 18 on the state side instead of 15

and see what happens there.

>> It was 8.

>> VICKI SCHMIDT: Probably won't have to go that high.

>> CHAIR PROFFITT: See what it does.
>> VICKI SCHMIDT: 18.
Yeah.

>> Those look right for you.
>> VICKI SCHMIDT: I think so.
>> 18 for state plus 15 for Blue Cross Blue Shield and 0 for Aetna.
>> VICKI SCHMIDT: That's correct.

>> For 27 a positive 12.1.

>> VICKI SCHMIDT: Can we back it down to 15.

thank you.

>> 4.5 for 27, ma'am.

sorry, 16.
Yes, ma'am.

>> VICKI SCHMIDT: I do hear 16 1/2.
>> What to you want for ending balance.
>> VICKI SCHMIDT: I don't know.
>> At 15 it was 4.5.
That would put us at right about 7.
>> VICKI SCHMIDT: I'm good.
I feel like I'm on one of those shows where they have 30 seconds to get a number.
Never mind.
>> So long as Commissioner Dechant has the over/under on that, we're all right.

>> CHAIR PROFFITT: So to recap your motion Commissioner Schmidt, if you could Pete on the first tab, the changes tab.
I'm sorry, the percent change.

the motion on the table would be to increase Blue Cross Blue Shield employee contribution by 15 percent Aetna by 0 percent and employer by 16 percent.
Correct all right.
That's the motion, do we have a second?

I'll second for sake of discussion.

Commissioner Sutton.
Second, Commissioner Sutton.
Discussion?
Commissioner Sutton.
>> BILL SUTTON: Thank you, Mr. Chair.
Can we go back to the projection summary. I want to make sure I'm understanding correctly.
That we are now going to at 28 ending with a -- almost a $40 million surplus.
Is that assuming 15 percent increase every year.
>> CHAIR PROFFITT: No.
Go ahead.

>> 16 this year and 3.9 the following year.
That's the correct balance back out so it zeroes at 30.
>> To add one more thing, because of the word surplus, I want to make sure we are all going to same place.
Go back to the summary tab.
This would show a reserve balance of 39.8 at the end of the year, but one thing that I do want you to keep in mind is that this balance is also what is used to pay your claims that are incurred but not reported.
So those are claims that we know have happened, people have gone to the there, they've seen the doctor, those bills are going to going to, they just haven't come in yet, and last time that liability was estimated for you, it was about 35.

>> CHAIR PROFFITT: To put a finer point on it.
This climbs to a target balance in 2030 that is tied to the statutory target balance.
So 40 million sounds like a lot, statute dictates a average of average claims, that's why this in 2030.
Half of where it should be.
>> VICKI SCHMIDT: Just a reminder that the employee increases.
>> JENNIFER FLORY: The employee increases take effect on effect/1/27 and the employer doesn't change until 7/1 of 2027.
So it goes with the fiscal year as opposed to the calendar year.
That does affect kind of how the numbers flow.

>> CHAIR PROFFITT: Further information.
Cops to the employer, about 85 percent of the total employer contribution is -- the other fee funds and other funds that make that up.

>> We'll get into that later.

still taxes.

>> CHAIR PROFFITT: Further discussion on this motion?

>> Go back to the summary part of that at the top, I guess.
Yeah.
So you don't want to have about 5,000 employee -- the Aetna employees would have no increase at all in their premium with this tiered the way it is.

>> VICKI SCHMIDT: That's correct.
I think you have to have the Delta of at least 15 percent if you want people to have -- to give people an option of switching Aetna for 0 or 15 percent from Blue Cross Blue Shield.
I mean that's about what the difference -- that's what the actuarial people said was the difference with the provider reimbursement and then the admin fee.

>> This -- the 15-0 doesn't get you all the way.
It's what we talked about, it gets you about 20 percent of the differential, which we feel like is a reasonable starting point to expect some migration and then also once you build that population and you can sort of evaluate some of these concerns that you've discussed and whether or not they continue to be concerns, can act from there.
It's a good starting point to incentivize some movement if that's the desire.

>> What's the bottom -- what's the ending projection then again, I'm sorry.
7 million.
Okay.

>> CHAIR PROFFITT: Go to the very first tab.
I can't see the tab names at the bottom.
Whatever that's called.
>> The rates tab, yes, sir.

>> CHAIR PROFFITT: The far right where you see the price difference on a monthly basis for each of the plans.
I'll give my thoughts here.
I might have to vote.
I don't love seeing a 15 percent increase for the plan that has the bulk of our employees, we did talk about having a choice that still does provide a choice for those that are more sensitive to cost than they are to going to a relationship with a particular carrier.
With it feels like a big see-saw going up to 15 and out years going to 4.
I know we have an immediate cash need we are trying to going to.

Something has to happen.
I was not comfortable with the previous one because the employer and employee contribution were the same.
Made my feelings known on the employee pay plan and making sure we are taking going to of employees.
I could get there since there's a 0 percent option for employees.
Should my vote be needed, I could get there based on having a 0 percent option for employees, I don't love this, but we have tough choices ahead of us.

my thoughts.
Commissioner Cain.
>> CRISTI CAIN: I believe I would need to make a substitution motion to do this, but could we look at look percent Blue Cross Blue Shield and 0 percent Aetna again and I don't remember what the projection was.
>> CHAIR PROFFITT: Leaving the employer at 16.
>> CRISTI CAIN: Yes.

>> CHAIR PROFFITT: Are you making that substitute motion.
>> CHAIR PROFFITT: Substitution motion.
We'll see what the impact is.

>> 20.9.
>> CHAIR PROFFITT: Just short of 3 million in 27.

being the numbers, is there I seconds on substitute motion?

seeing none, substitute fails on lack of second.
Back on the original motion, 15 percent Blue Cross Blue Shield.

>> I would like to comment that we could go with a 0 intent and 10 and probably make up the difference in bottom line with the bulk of the plan changes that I had suggested be considered.
Yes, it's nickel and diming, but it does bring about another 3 million.
Which would be another way of getting close to the 6 or 7 million ending balance in 27, and keep the Blue Cross Blue Shield to a 10 percent raise.

>> CHAIR PROFFITT: A substitute motion or a comment.
>> That was a comment.

>> CHAIR PROFFITT: Further discussion?

hearing none, we'll take a vote.
To remind everybody, the vote is for no plan design changes beyond what was required by the I.R.S., 16 percent employer contribution, 15 percent for employee, 0 percent in Aetna in plan year 27.

>> CRISTI CAIN: Nay.
>> STEVE DECHANT: Nay.
>> BILL SUTTON:
>> VICKI SCHMIDT:

>> CHAIR PROFFITT: Okay.
Motion fails.

>> CHAIR PROFFITT: Any other.
>> I would make the motion that we from this, decrease the -- I didn't want to mess with a substitute, decrease the Blue Cross Blue Shield change to 10, excuse me, and reinstitute the plan changes that I had proposed previously.
>> CHAIR PROFFITT: Identify those, please.
Or if Pete can do those.
>> Can you help me on that, please.

>> CHAIR PROFFITT: Want to make sure we are Crystal clear on what we are doing going to.
>> Thank you.

>> JENNIFER FLORY: Plana increases the deductible to 1,250/2500.

Plan C and n, it's 3450 which was now 3500 and 5700.

and single goes to 29 on both of those.

then we'll go to out of pockets, plana will be 5500/11,000.

Plan C is 4750/9500.

Plan N is 6900/1380.

and j is 7600/1520.

>> CHAIR PROFFITT: For the record, it was leaving the employer increase at 16 percent.
>> Yes.

>> CHAIR PROFFITT: We'll see this before we ask for a second.
27 ending balance is six-point -- little under 6.8 million and if you can show year or tab.

scroll up -- that's the split.
You're good, you're good.
>> Full-time rates right there.

okay.
So that was the motion, is there a second?
Second, Commissioner Sutton, discussion?

seeing none, we'll move straight to the vote.

>> CRISTI CAIN: Aye.
>> STEVE DECHANT: Aye.
>> BILL SUTTON:
>> VICKI SCHMIDT:

>> CHAIR PROFFITT: Chair votes aye.

motion pass.

I'm sorry, is your mic on.

>> VICKI SCHMIDT: Could I do an explanation vote, please, thank you.

>> CHAIR PROFFITT: Just within the next week, please.
If we can have it within the next week.
If you have it now.
>> VICKI SCHMIDT: I'll give it to you in a couple of days.

>> CHAIR PROFFITT: Okay.
Terrified to ask, are there any further changes anybody would like to make, want to make sure we are in a good spot?

okay.
All right.
>> May I make a comment.
>> CHAIR PROFFITT: Please.
>> Certainly not speaking for the rest of the Commissioners, but my motion was not one I took lightly given the dramatic changes not only in out of pocket direct costs on the monthly basis, but as well as to the deductibles and coinsurance and those kind of things, but we have ended in a -- we are looking going to ending in a terrible position this year, and what we have done with these changes is simply

hopefully ending in no worse terrible position a year from now.
I'm not sure what we'll do if we have a similar course of events that occur early in 2027 that would simply wipe out the projected balance we have I'm hopeful.
That what we project is what's going to happen, and we definitely need to see what is projected then into 28 and beyond.
And a future commission, we've got to look at that target balance as not just simply a fun thing or a nice thing, but something that really has to be taken seriously.

so that when circumstances happened with expenses, we can easily absorb it and not be looking at having to make wild -- I don't mean wild in terms of crazy, but large, dramatic changes just to stay precipitously solvent.
So, again, for myself, I certainly didn't do so lightly, but feel in terms of being responsible that it had to be done, and again, say to all of us we need to look into the future years and not let our -- even though we had a projection of 24 million, I believe that's what it was for the end of this year, that got wiped out almost immediately, and so we see what kind of a swing can happen.
And we have got to let that balance get back up there where we think it should be or, I guess what is legislatively mandated which is what we used to go by I think by almost 20 million on some of the out years, I think what's happened, demonstrates we have got to work to keep that or stay pretty darn close to it.
And not feel like we are flush going to cash.
Just because we got 60 or $70 million reserve.
We have got it for a going to reason.

thank you.

>> CHAIR PROFFITT: Noted.

along those same lines, as we look toward future health care commissions and whoever might be sitting in these chairs might be -- my comfort level with being able to get to a yes vote here is there is a 0 percent price increase option on the monthly premium, a price increase on the back side should somebody back up against the out of pocket max.
But as I look at the out years the 3.9 percent, my sincere hope for whoever follows us in these chairs we stick to that or find ways to kind of mitigate that and I -- given what I do professionally, I understands the numbers quite well, probably as well as anybody, those are hugely important, and we have to take those into consideration, the other side of the mandate, the statute for this commission to provide the best possible coverage for state employees and take that into account as well, that's my sincere hope for -- as we move this thing forward.

that would be my explanation of vote.
All right.
Having exhausted the end of our agenda, would just note the next meeting scheduled is August 18, to 26 I think we are back going to 9:30 for that one.
We will have more information as it relates to GLP-1s with AOMs and I'm sure some other things we'll be discussing at that point in time.
I would entertain a motion to adjourn.

>> So moved.
>> CHAIR PROFFITT: Is there I second.
>> CRISTI CAIN: I'll second.
>> CHAIR PROFFITT: All those in favor, say "aye."

[chorus of ayes]
opposed?
We are adjourned.