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KANSAS HEALTH CARE COMMISSION MEETING
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>> CHAIR PROFFITT: Are we good to go?

I think that is my sign, very good. Thank you so much. Pete. I would like to welcome you to the August 22 Health Care Commission meeting. I appreciate everyone joining us today both in person and online. We are short one commissioner, but we have a quorum. We'll get started. We have a rather lengthy and hearty agenda today. In the interest of time, want to make sure we get to it and leave plenty of time for robust discussion as we always have. Before we get going, I want to take a moment to thank director Conroy and the entire KPERS organization, appreciate them allowing us to use their room and also the news spread up here, which I believe is open to anybody in the audience should you choose to get a coffee or cookie. It means I'll eat fewer of them. With that. We will jump into roll call before we get to action items. Commissioner Kane.

>> CRISTI CAIN: Here.

>> CHAIR PROFFITT: Commissioner decant. Commissioner Hensley. Commissioner Hensley, we show you are online, but not hearing you in the room. If you can check your mouth button, please.

We'll come back to him, commissioner McGinn.

>> CAROLYN McGINN: Here.

>> CHAIR PROFFITT: Commissioner land we are.

>> BRENDA LANDWEHR: Present.

>> CHAIR PROFFITT: Chair is here. Commissioner Hensley, are you able to speak with us?

We will reflect he is online and not able to connect through his microphone and can chat things in if needed. I'm seeing commissioner Dechant walking in the room right now. The materials were sent to you last week, first action item, a review of the minutes before I ask for a motion, I do have one point of clarification I think needs to be changed. It is on page -- pardon me, just had to pull it up.

Page 8, as it relates to the discussion on direct bill Non Medicare early retirees rates. There was a motion to table before the August discussion, I believe it was me that made the motion. Update the minutes to show it was the chair and not commissioner Dechant. Any other comments, questions or edits on the minutes?

Hearing none, I would entertain a motion to approve as amended.

>> I move the -- I'm sorry, Mr. Chair.

>> CHAIR PROFFITT: Commissioner land we are.

>> BRENDA LANDWEHR: I move they be adopted as amended.

>> CHAIR PROFFITT: Second by commissioner Dechant. Any opposed?

Minutes are approved.

Thank you. Okay, we are going to move on to action item 2, which is discussion on the Medicare part d contract. For that, I believe director Flory will give the presentation. We should be in tab 2 in your books.

Director Flory.

>> JENNIFER FLORY: So the Medicare Part D contract is for prescription drugs for our Direct Bill members. Let's move to the next one, Pete.

The Medicare Part D covers prescription drug insurance for members on Medicare Part D. It's available to the Direct Bill members covered under our Medicare insurance through Blue Cross Blue Shield Kansas, a standard Medicare Supplement insurance, an optional program employees are selecting that Medicare Supplement insurance can elect to take it from the state or they can buy one in the private market. The current vendor we have is SilverScript. So on the next slide, we did put this out for bid. Two bids were received. They were from SilverScript and Humana.

We entered into negotiations with both vendors, both of these vendors are known vendors in

this space and capable of providing the services being requested in this RFP.

On the next slide, again, the prescription drug benefit is an optional program, we do have this for the Medicare Supplement insurance. It's an important distinction that the Medicare Advantage programs include prescription drug coverage. So anyone who is selecting one of the Medicare Advantage programs already has a prescription drug plan and the rules don't allow them to select a different one.

They either have to accept the one with the advantage or go without.

This is strictly for our members who take our Medicare Supplement insurance and, again, they can choose it or choose one in the private market.

As we looked at the bid evaluation on the next slide, we looked at what the members premiums would be, making sure they had access to broad networks, both vendors have adequate networks for our members. The ability to offer our Direct Bill members a choice in plan design is important. The member formulary impact. Customer service and the ability to handle the eligibility and big process. Unlike the Medicare Supplement insurance in which the state insurance employee health plan does the big, the vendor does the big directly to our members.

So that's just a little bit different structure.

On the next slide, we are going to go through a look at who currently has our Medicare Part D enrollment. On the right hand side, you'll see the total number of eligible members we have that would be enrolled in the Medicare Supplement insurance. We have 7,192. Of those 5,213 have waived the Part D and chosen to go to the private market. With the two options we offer, which premiere is a very enhanced med Medicare Part D plan, it has a lot of benefits, we have 1,558 members enrolled. It is the program we have offered pretty much since the beginning of Medicare Part D and has continued to be the most popular option with employees the whole period of time.

With this particular vendor, we added an economy plan. This was designed to bring in a program that looked more similar to some of the lower cost options in the private market. And that program has continued to pick up a number of members each year, and it now has 421 members. So it is a lower cost option.

On the next slide, we are going to show you what the rates came in with this RFP. In the second column in hot pig, you will see what the current rates are for our program, and next to them, then you will see the bid rates by SilverScript and Humana for both the premiere plan and for the economy plan.

As you can see, SilverScript is the lower cost option for both the premiere and Medicare Part D plan.

With that, I will entertain any questions that the Commissioners may have regarding the vendors.

>> CHAIR PROFFITT: Thank you for the overview. Commissioners, any questions for Director Flory?

Commission Dechant.

>> STEVE DECHANT: This is Steve Dechant, thank you. Any thoughts or what -- on why the significant difference in the premiums.

>> JENNIFER FLORY: Looking at the vendors, Humana is a known vendor in this space, and we really weren't able to discern a reason why their bid was significantly higher. I can tell you that SilverScript did, on their best and final, reduce their rates and added some enhanced benefit options, which sweetened their offering considerably. But I really don't know why Humana's bid was significantly higher.

>> STEVE DECHANT: So the benefits from SilverScript will be better than they've been over the past several years with them.

>> JENNIFER FLORY: Yes, they included enhancements to reduce a couple of the copays on the premiere and there was one other option, what was it, do you remember, Pete, Paul?

I know they were reducing -- yeah, the preferred on generics, there's a preferred and standard copay, and they reduced some of those copays on those generics.

>> STEVE DECHANT: What sort of numbers increase have we seen over the last couple of years in the economy.

>> JENNIFER FLORY: The first year we offered it, I think we only had close to around 100 members, so it's just gradually increased over time as I think originally when we offered it, one of the questions our Direct Bill call center got from people is what's the catch? Why is this so much less than the other one, and we have done a lot of communications with them to try to explain that, this program, it's just structured differently than the premiere, and there are some copays, and it's just similar to what's available in the open market. There really isn't a catch.

As time has gone on, I think there's been more comfort with the Direct Bill population in the fact that it is a program that they can take and that there isn't really a got ya out there waiting for them.

>> STEVE DECHANT: This is our 4th year, where are we at with the economy Part D.

>> JENNIFER FLORY: Do you remember? Mike thinks it's around five. Yeah.

>> STEVE DECHANT: I think it's good we did over that. The premiere Part D is a Cadillac plan.

>> JENNIFER FLORY: It is.

>> STEVE DECHANT: I think for some folks who didn't want to go out for whatever reason and look on the open market, the economy is probably more fitting, and I'm glad that people are seeing they can get the coverage they need to have without paying the premium for more maybe than what they did. I'm glad that we began that and I'm glad that it's seemingly meeting the needs of about 20 percent of the population, at least, that stay with the state plan.

That's all I have, thank you.

>> CHAIR PROFFITT: Thank you, Commissioner. I have a couple of questions, director Flory, you mentioned that Simms offered additional -- SilverScript offered additional benefits. As the RFP, the bids were submitted. Were they to bid on similar products or what was the direction?

>> JENNIFER FLORY: The direction was to bid on the products as they exist today, as close as they can, because these are filed products with CMS, there were minor differences with the Humana offering. They didn't have like the two levels of generic, they just had one level of generic coverage.

Then the bidders are also given the opportunity, so once you've bid on what we have today, you can propose other options to us as well. Humana did propose another economy-type plan, but even that economy-type plan, which had less benefits than we currently offer still had a higher price than what SilverScript had recommended.

>> CHAIR PROFFITT: The initial bid was largely similar and related to the design plan in place today.

>> JENNIFER FLORY: Yes.

>> CHAIR PROFFITT: Both have an adequate network. Is there a noticeable difference between the two. Does one have a broader network than the other.

>> JENNIFER FLORY: SilverScript has a slight advantage in the network they have, like 16 more pharmacies than what Humana has, but overall, either would have a significantly broad network to access for our membership.

>> CHAIR PROFFITT: Okay. Very good.

Commissioner Cain.

>> CRISTI CAIN: Director Flory, I wanted to ask about the 80 percent of people are waiving this. I mean, is it because they can find cheaper coverage on the open market? I'm trying to understand the reasoning or do you know why so many are waiving it.

>> JENNIFER FLORY: Well, initially when we began offering Medicare Part D, we went in with a Cadillac option. We had coverage through the donor hole that wasn't available in the private market. So our program was more similar to what our members had been used to, and, of course, the price was higher.

They were allowed to go out and shop the private market and, as they retire, many of them do and I find that if a person is using very few medications, low cost generics, they may be able to find coverage out in the private market, but what we hear from our members is pretty much what we have talked about here in this forum before. For the members who choose to stay with the state, once they retire, they do so because they have a comfort level with the fact that we are vetting the products on their behalf and some of our members simply don't want to take on the task because comparing Part D plans can be very, very -- it's it can be very time consuming and very confusing because each vendor has a little bit different wording and a little different structure.

For some members, they choose just to stick with the state because they look to us to do that for them. Other members are maybe more savvy with their dollars, and want to shop.

>> Christy, may I respond to my question. For myself, I'm one of the 80 percent. My premium is much lower than $42 a month. That meets the needs that my wife and I have. And I think it's been pointed out, you've got to look based on your needs. And then for what our needs are, we can do it for a third of the price that the economy does.

If that were to change down the road, I would be open to looking at the economy or premium if necessary, and that's my guess on probably most of the 5,000 or so that the open market offers a good product for them. And their needs at the time at a better cost than what the two state plans are offering.

My comment, I pushed for having a second level because I figured there were folks who didn't have the acumen or desire or whatever and could go to a good product for themselves at a much reduced cost from the premium plan as we call it now today.

>> CRISTI CAIN: Thank you.

>> CHAIR PROFFITT: All right, any other questions, any questions from online commissioners?

Hearing none, Commission, we are at the point where we need to make a recommendation of which of these we proof forward with and offer a three-year contract with. Open to a motion.

>> STEVE DECHANT: I move we award the three-year contract to SilverScript for the plan and the pricing that they have presented to us.

>> CHAIR PROFFITT: Very are good. A motion, do we have a second.

>> CRISTI CAIN: Second.

>> CHAIR PROFFITT: Any questions or discussion?

Hearing none, Commissioner Dechant.

>> STEVE DECHANT: AI.

>> CHAIR PROFFITT: Commissioner cane.

>> CRISTI CAIN: AI.

>> CHAIR PROFFITT: Commissioner Hensley.

>> ANTHONY HENSLEY: AI.

>> CHAIR PROFFITT: Motion carries. We'll move on to action item three. Medicare Advantage rates for plan year 24, and commission, this is in tab 3 of your book. We will start on page 21 of the deck. Again, director Flory, I believe you're taking us away.

>> JENNIFER FLORY: Each year the Medicare Advantage program has to work with CMS on the funding since Medicare Advantage plans are med car part c, sometimes called MA plans, there's a component that the funding that comes through Medicare, so instead of having Medicare a and Medicare b, it's all combined into Medicare part c. Because of that, then the vendors have to work with CMS, develop their rate structuring and then we have to bring those rates back to the commission for your approval each year because they do change over time. Currently we have 834 members who have elected to take one of our Medicare Advantage plans. We can jump two, Pete.

On the next slide, we have the two benefit offerings we have today, through Aetna, we have the Aetna freedom PPO ESA and Aetna elite PPO ESA. The 2023 rates as well as the 2024 rates. The rates are for the third year of the contracts, and we do require -- it will require Commission action to approve those rates. Aetna has proposed a $15 premium increase per month for both of the programs for plan year 2024.

And with that, we can take questions if the Commissioners have questions.

>> CHAIR PROFFITT: Thank you for the overview. Commissioners, any questions?

Hearing none, Director, I believe our action item is to make a motion to accept these rates should we so choose.

>> JENNIFER FLORY: Yes.

>> CHAIR PROFFITT: Do we have a motion?

>> STEVE DECHANT: I move that we approve the Medicare Advantage rates as presented to us.

>> CHAIR PROFFITT: There's a motion. Do we have a second? Second, commissioner Landwehr. Any discussion or questions.

Hearing none.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> BRENDA LANDWEHR: Commissioner McGinn.

>> CAROLYN McGINN: Aye.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: We are cooking with peanut oil.

Moving on to action item 4, discussion on the Direct Bill Non Medicare rates, tab 4 for those in the physical book. Those online, we move to slide 25 and director Flory has the floor again.

>> JENNIFER FLORY: We do have a report from the EAC president.

>> CHAIR PROFFITT: I got out of order there, thank you for correcting me. Judge Showalter will come up and give a report based on the EAC discussion yesterday and what their recommendation would be. Judge?

>> SCOTT SHOWALTER: The EAC met yesterday, we discussed at length the circumstances behind direct pay, and it was decided unanimously that we believe that it's appropriate for the commission to go ahead and approve direct pay. Bringing the folks back into the system. Although it might be an expense to the state we believe would be worth it and would hope the Commission would consider our recommendation.

>> CHAIR PROFFITT: Very good. Thank you. Just a clarifying question. The question at hand, effectively do we move back toward blending the Direct Bill Non Medicare members into the Plan A or Plan C, wherever they might fall.

>> SCOTT SHOWALTER: That is our recommendation.

>> CHAIR PROFFITT: Thank you. Any questions for the EAC before we move on to presentation?

Okay, hearing none, thank you. Appreciate your report. So now director Flory? Very good, thank you.

>> JENNIFER FLORY: So again, we want to go back and take a look in time. Plan year 2015, these were the rates that an individual who was in our direct bill program who hadn't reached Medicare eligibility yet would have paid for their health insurance. Actually, this rate would have also applied to people who were Medicare eligible back in 2015, the rules changed to require Medicare eligible people to move to a Medicare product, I believe, in plan year 2016. But in 2015 this is the rates that would have been charged for those members who were considered Direct Bill, not yet -- they could have been Medicare eligible, and these are the rates we would have charged for them. Let's move forward.

So let's talk about what we mean by Direct Bill members, so our Direct Bill program is the term that we generically use to cover individuals who we bill directly for the cost of their health insurance.

With this program for those on the active employee membership, it would include members who are formerly elected officials, as well as former employees that continue their health insurance coverage with the state employee health plan.

Today the rules require that to be a part of the active employee membership, you do have to not be Medicare eligible. That was a change that was made to force the Medicare eligible members to move to a Medicare product. The Direct Bill members pay 100 percent of the cost of the coverage. That would include any contribution that previously had been covered by the employer, as well as an employee rate.

Historically, prior to 2016, those rates were blended with the active employee rate. And during a period of that time starting in plan year 2016. That changed. That blending, it does create about a $10 million implied subsidy. It's made up in the difference in the cost of the premium

as well as claims experience for those members. Two what we collect and what we actually spend for those members. It was about $10 million for that blend.

The A&M report, did recommend, a legislative company that came in and did an audit. They recommended we eliminate this blending because it resulted in a GASB liability, which is a liability statement that is required to be put on the balance sheet that shows an estimate of how much that implied subsidy would be over the course of that retirees life span. So it's a number that goes on the balance sheet.

So moving forward, the decision was made to stop blending that rate and at the same time, we also moved those Direct Bill members Medicare eligible off of the plan.

In 2016, our Direct Bill Non Medicare members saw their rates increase 21.3 percent, and then again in plan year 2017 they saw a 46.1 percent rate increase. And that was based upon trying to rate that population based on their claims expense and their premium as a pool. It was a pool of about 1,000 people.

By doing that, it made our COBRA rates more attractive to our Direct Bill members. As a person is leaving the state, whether that be an elected official who is leaving or a person who has been an employee, the COBRA rate we are required charge is federally formulated. That formula results in a lower premium rate for those members. So for 18 months, most Direct Bill members go onto COBRA and at the end of the 18 months move to Direct Bill. That creates a lot of administrative work in the HR offices in helping people to understand and get them all processed through.

So the Non Medicare enrollment in plan year 2015, before we started making all these changes, was about 1,000 people. And today it's dropped to a pool of about 286. I think probably at the high we saw maybe 300, 315. But we continue to see it's somewhere in that 250 to 300 range.

So on the next slide, we talk a little bit about what does it mean if we were to go back to doing this. Keeping in mind that the rates the last couple of years the Commission has approved, the Direct Bill population has the exact same rate increase the active population got.

What we are talking about the situation that occurred historically that resulted in the big increase. So the impact today, if we were to go back and reblend this would be $1.9 million. That would break out to being about a $900 impact -- $9,900,000 impact as a result of the claims expense of these individuals. As well as the reduction in premium, which is about $970,000 in lost revenue by making this change.

If we looked at the contribution on the spreadsheet that Segal puts together where we show in plan year 2026 that we would need a 4.6 percent rate increase, this would add .3 percent to that current increase.

The goal in making the change was to eliminate that GASB liability, to get that off the books. It is currently at zero. When we look at other states, most states do provide some type of subsidy towards their retirees, some of them do it through the blending, some of them may do it through premiums. Not every state does, but we have seen states that do have considerable contributions towards their Direct Bill membership.

So the current year, GASB liability in 2015, again, that -- we still had Medicare members that were on the active employee plan, it was 130 million. We have had Segal look at this. Based upon our current membership, that GASB liability would be 20 to $25 million.

We project that the increase -- this change would result in an increase in the number of individuals who stay on the state employee health plan when they leave employment, and that would gradually increase over time and by 2027 we could potentially see 1,000 members return to this pool.

On the next slide, the new contribution proposal would reduce the rate for these members to be lower than the COBRA rate. It would simplify a lot of processes at the time the individual is leaving state service.

It potentially reduces our COBRA rate just the administration we are paying, but that change is really -- it's minute, it's like $7,000. It's not a big amount of money, but there is a slight reduction by doing this.

Potentially we could see our Direct Bill enrollment increase, which would be a positive for our future plans.

Then in the appendix again, if the Commission is okay, would you like me to go through the rate changes.

>> CHAIR PROFFITT: Please do.

>> JENNIFER FLORY: Let's move ahead, Pete, until we get to the Plan A scenario. We looked at plan year 2023, to see what would happen if we were blending these rates. If you look at the employee only line, you'll see that the current COBRA rate is $755.72. Our current Direct Bill rate $958.60. And if we were blending these, we would have a rate of 690.74. Which is a savings of $267.86 per member per month. Currently we have 78 individuals who are enrolled in Plan A, Direct Bill, employee only coverage. You can see the savings if they have a spouse and dependents and the math works the same way on those. We do not have a lot of dependents in this population. It's mostly -- there are a few spouses.

On the next slide, we'll show you what happens with Plan C, Plan C is by far our most popular program for our Direct Bill members. The employee only current COBRA rate is $639.88. Our current Direct Bill rate is 70.62. If we had blended them, it would be 446.72. Saving our folks $260.90 per month, and there are 144 members that would affect.

Again, we have a few more spouses on this program. It is a little less expensive because of the way the program is structured with that early deductible.

Plan j is the next plan. It is specifically designed to meet the needs of an individual here in the U.S. on a J1 Visa. One that has very limited enrollment and meets a specific need in our active employee population. Not particularly popular with our Direct Bill members because it is more expensive. It also wasn't around in 2015 and 2016 when all the big change was made to the rate. You see the savings is very slim. Current rate with 782.55. If we blended it, it would only drop it to $745.38. A savings of $37.17 per employee per month. Because it wasn't involved in the big change, it doesn't have the big savings either.

The same thing can be said of Plan N, the current rate for a Direct Bill member is 681.82. COBRA rate 658 and the current, if we were to have blended this in plan year 2023 would be 645.10. "Savings of $36.72 for the 14 current enrollees in the employee only program.

With that, I'm open to questions.

>> CHAIR PROFFITT: Thank you for the report, and for all the detail and also for providing the scenarios, I think that helps illustrate exactly with why we are having this discussion.

With that, we'll open it up to Commissioners if there are comments, questions. Commissioner Landwehr.

>> BRENDA LANDWEHR: Maybe I'm not understanding these numbers. What is the current cost to the state and what would be the cost if we go back to what we were doing before.

>> JENNIFER FLORY: The current cost is that $1.9 million, which is the difference between the premium that is being collected and the claims expense. The additional claims expense, these members incur results in that $1.9 million cost to the state for doing this.

Then you would be the other item the GASB liability, a number you have to book on your accounts to show the potential blending cost over the course of time that a member is a retiree. It's an accounting number. I can't see, Commissioner Landwehr's.

>> CHAIR PROFFITT: Depends on your perspective, I suppose.

>> There's an open seat.

>> That would be me.

I guess I'm still a little bit confused, I'm not saying it's because you're not saying it right. I'm just not grasping, so it's the 1.9, plus the 130 number, the GASB liability.

>> JENNIFER FLORY: So the GASB liability -- can you jump -- Ken, can you jump in.

>> CHAIR PROFFITT: The $130 million GASB liability is what that GASB was in 2015. Which I believe, I was not here, I read most of the report, why the study during the efficiency study said we should eliminate this, stop blending the plans. We were booking $130 million liability as a result of blending experience at that point in time. Should we move forward, Segal has rejected that by blending the current population up to 1,000 projected with the current membership and across whatever plan they might fall into a GASB liability of $20 million. The GASB liability as director Flory explained, is -- I'm not trying to minimize it because I do have concerns any time we put liabilities on the books, that falls directly under my shop. I have to sign off on the act for every year, but it is a potential that should the plan become I will liquid, what the state would be on the hook for to fund that as it runs out, it is not a direct cost to the state. It is an accounting booking, almost like a contingent liability. It is not capital outlay of $20 million unless the plan becomes I will liquid. If that becomes the case, we have much larger problems, I hope that helps.

>> BRENDA LANDWEHR: That's on the GASB.

>> CHAIR PROFFITT: Correct. It was $135 million when the decision was made to stop blending back in 2015.

>> BRENDA LANDWEHR: What would we be putting back on the books.

>> CHAIR PROFFITT: That's the $20 million.

>> BRENDA LANDWEHR: Struggling with those two numbers, thank you, Mr. Chairman.

>> There's really two numbers that go on the books, one is the cash position, what you'll pay out. That's the $1.9 million Jennifer mentioned. How much is the state going to pay. Then the GASB liability, which is -- it is a book number, but it's based on what do you expect or the lifetime of all the people that the liability. The so if it does go insolvent, that's a number that would need to be out there to pay out the liability for all time. Kind of like a retiree pension plan too, same kind of long-term liability number. I don't know if that helps. Next year 1 point -- 1.9 million cash liability. It is a real number that over time, that's what you would pay as the state. Over the next 20 years or whatever the number would be.

>> CHAIR PROFFITT: I would note for the record our OPEB liability is remarkably low in the state. It is a decimal of a percentage overall for the state's total professional portfolio not just the health plan.

>> CAROLYN McGINN: I have a question. I just want to make sure I'm totally understanding this. So that we can provide COBRA for people who have quit.

>> JENNIFER FLORY: No, COBRA is a required benefit. This would not affect the COBRA. This is for employees and elected officials who leave state service, they are not yet ready for Medicare, and this is what we charge them for the cost of their coverage, which includes what the state would have paid when they were an active employee, plus the employee contribution. It's one big number for them. So they go from an active employee where they may be paying $20 per pay period when they become a Direct Bill member, on Plan N that we have up here right on the screen right now, currently we charge them $681.82. Where currently they are paying $20 per pay period for that program.

So it's the total cost of the insurance, but by blending it, we could reduce that $681 down to $645.10.

>> CAROLYN McGINN: Okay. I just heard earlier in your history, you were talking about COBRA.

>> JENNIFER FLORY: The employees currently, because the COBRA rate is much cheaper than what our active employee rate is, when members leave state service, they generally will take the COBRA rate and COBRA program, and we have to pay the administrative cost for that, and take that for 18 months and then at the end of the 18 months, then we have to transition them to the Direct Bill program.

Does that help.

>> CAROLYN McGINN: Well, I guess I just -- I'll have to have a side class. I don't understand why we are paying for anybody that quits, once they quit.

I know that you can stay on and pay, and I guess that's what these folks are.

If you continue to stay. You can't quit and then come back a year later, you have to continue, correct.

>> JENNIFER FLORY: So these individuals are people who generally have retired from state service, or they were an elected official and either didn't seek reelection or did not win reelection that are paying in the Direct Bill population.

COBRA can be used for a young person who might be leaving state service or maybe it's a spouse in the case of a divorce that would become eligible for COBRA. Those continuation rights come to us under federal law, and so that provides that 18 months of required coverage and the federal COBRA law sets how the contribution is structured, and those numbers are based upon what the state is contributing towards an active employee plus the employee rate and there's a formula that's used to create those COBRA rates.

COBRA, the reason we talk about COBRA is because that rate, the way it is federally put together today, it is less expensive than what we are charging our members who are what we call Direct Bill, those retiree people who have qualified through their state service to continue their coverage as a retiree, they've met those qualifications, that's the Direct Bill rate we are talking about. That if we were blending it, with the active population, we could reduce that number a little bit and help those members.

Once they become Medicare eligible, we force them to take one of our Medicare programs or they're free to leave and go to the private market and buy something of their own choosing.

>> CAROLYN McGINN: I'm just saying if you were in private industry, they wouldn't be doing any of this. But you're saying it's because they met the terms of their retirement is why they get this offered.

>> JENNIFER FLORY: I don't know that I would agree with the statement that if they were in private industry they wouldn't be able to get some type of benefit as a retiree, because many large employers who are of similar size to us do offer some type of program for their retirees when they leave their service.

Many of them do it up until the time they become Medicare eligible and then once they become Medicare eligible, they may discontinue their coverage options, but we do see that a lot of large employers do offer some type of benefit towards their Direct Bill or their retiree population, at least to the point to get them to Medicare eligibility.

>> CAROLYN McGINN: Okay. Thank you.

>> CHAIR PROFFITT: To clarify, yes, this is for employees that are separating from state service, whether it's an employee or elected official. Yes, by blending the -- this population with the other population, whichever plan might be there, would be additional costs to the state. I want to make sure we are clear about that. The $1.9 million cash outlay and the GASB liability that goes on the books. The question is do we offer a better benefit for those that have dedicated their careers to public service, to bridge that gap between as an example, age 62 person who has been here for 30 years has 92 points and needs the 3-year bridge to

get to 65. Right now options are COBRA or paying more for the Direct Bill rate. Do we take advantage of the blending to a different population to reduce that at a cost to the state. There is a cost to the state. That's got to be a part of the decision. Commissioner Landwehr.

>> BRENDA LANDWEHR: This is where I struggle, Mr. Chairman, is that you're wanting to provide a benefit to individuals that chose early retirement. And by taking their early retirement, many of them go work somewhere else.

Not all of them, but a lot of them do.

So we are going to make taxpayers pay for someone's -- an individual's choice to take early retirement, and that's not a widespread benefit in the private sector. It's just not.

So that's why I have a real problem with this, that we are going to -- because we keep talking about the employer picking up this, the employer picking up that. The taxpayers are the employer.

And that's the piece that we can't do. That's why I don't agree with this system -- this change.

>> CHAIR PROFFITT: Any other comments from any other Commissioners.

>> STEVE DECHANT: Could you turn back to the difference in the GASB liability as it was projected in 2015, where it was 130 million and the current and why is there such a tremendous change of $100 million increase in the liability over that -- in that time frame.

>> CHAIR PROFFITT: A wonderful question, I don't know that I'm qualified to speak to the difference. I don't know if our actuarial friends or director Flory would.

>> JENNIFER FLORY: Remember, we didn't make the change to force individuals who are Medicare eligible onto Medicare populations, and so that resulted in a larger enrollment during that time period. When we made the change to say, once you become Medicare eligible, you must move to a fully insured Medicare product, those products, there is no employer subsidy on those, entirely 100 percent of the premium for those Medicare products pod by the member. We are talking about just the population that is before Medicare eligibility, and so that number would be much lower today. Because we are down to only 286.

>> STEVE DECHANT: Makes sense, thank you.

If I may, I'd like to comment.

I didn't ever work in the private sector, so I won't even try to speak to that. I worked in the public sector my entire career. I was an early retiree. Had my points, I forget what they were at that time, 85 at that point. But anyway, had my points, so I'm not even sure if I would say I was an early retiree. I earned my retirement, put in the years of service. That took me to the point where I could take a full retirement. I took one that was based on that salary, which was less than if I had worked another whatever number of years in my particular case.

For me at that point in time, it was my decision, and computing dollars and cents and that kind of thing, included what I knew of my insurance -- my health insurance would cost me.

I was fortunate in that I hit age 65 at about 2015-16 before these tremendous increases went into effect.

I feel for the people who got hit with that 20 percent and then the next year around that 40 percent and still had several years to go and some decisions to make, maybe they -- no, they wouldn't have been able to go to COBRA at that point. I think -- we talk oftentimes and certainly no matter what we do in terms of benefits at the state plan to current employees, it's -- those of White House pay taxes, it's at our expense, taxpayers expense, we talk about benefits to employees. I see this as a continuation of that. Happens to be a retired employee, who gave extensive service to the state in one fashion or another. And then it's an opportunity to, again, have that benefit as a public servant.

I used to say, and I don't know if it's true, yet, but I remember saying any number of times to be a state employee means that you probably earn a lower wage than what you might be able to earn in the private sector. But there are some benefits to state employment and in this particular case, to state retirement.

And I think that it's -- it's not out of bounds, and I think that it falls easily within talking about benefits and supporting our employees, this would be a support of our retiree employees if they choose to retire when they are eligible but earlier than 65, and then I think the change to require Medicare moving on to med CARE was a good change at that time -- Medicare was a good change at that time. Are I think to reinstate it is to right something I believe shouldn't have occurred in the first place eight years ago.

Thank you.

>> CHAIR PROFFITT: Thank you, Commissioner. If I can piggyback on that. Apologies, I'm probably going to sound like I'm on a soap box here.

I place a high value on public service and public employees, I've had the benefit in my career of I grew up in the private sector, doing that, came to public service, back in 2017. I did leave for a period of time and went back to private sector. I'm back because I enjoy it so much.

When I grew up, my career in the private sector, I had worked my tail off, I was literally in the office on holidays and weekends and working from home on vacation day just, a lot of my colleagues did the same to make sure we hit our mission.

That said, when I came to public service the first place that I landed was with the KanCare program. It became abundantly clear to me that I had never in my life been around a group of individuals who were more committed to the cause, more passionate about the work they were doing than in state employment. The individuals that I worked with just to this day blew me away there passion, knowledge and dedication to making sure that it is right. Most of them have had opportunities or probably still have an opportunity today to chase a paycheck. For those that choose to do that, great, do what's right for your family.

By and large the vast majority have chosen to give up the sweet neck tar of the profit sector paycheck to make sure they're here for public service. I commend that and want to make sure that we have very few opportunities to recognize that and to reward that in a financially relevant way at the state.

Our state statute as it relates to bonuses is incredibly restrictive. Can't tie it to performance, any guarantees, anything other than random event. It's capped at $3,500 a year. Quite often in the private sector, depending on what career you choose, looking at 10, 20, 30, 40 percent of your salary.

By doing that, you're looking at ways to compress cost and get margin. At the state we are looking at ways to better serve the public.

I'm fully aware of the impacts on the state budget as state budget director, I what have good handle of what the implications are. I understand every decision we have has an impact on the budget. I do not take these decisions lightly. Any time we add costs, we are increasing the base of our budget and increasing costs in the out year. Yes, the taxpayers are the ones that are on the hook for that. The state as an employer, the state is funded by taxpayer dollars. However, taxpayers dollars are funding employees providing critical services to those in the State of Kansas, all 2.9 million citizens across Kansas. If we don't have a dedicated work force, folks passionate about being here and spending their careers here, we risk reducing the impact of those benefits to Kansans. I look at the return on the cost to the taxpayers as well, I think there is value in that return.

And I know most of my Commissioners would agree with that. That's my particular perspective. So to the extent we can make retirement, take one of the hurdles to retirement, if it might be a couple of years out of it way as you're doing your calculations on what that might mean, is tier 1, slowly fades from the work force, get away from 85 points and move into tier 2 and tier 3, the calculus changes. Providing a more cost effective bridge to the Medicare transition, I think is something we can do as an employer in the State of Kansas to be an employer of choice and to recognize in a meaningful way the incredible appreciation we have for these employees that have dedicated their careers to public service. For those reasons, I would be supporting the motion should it make its way to the table. Commissioner Landwehr.

>> BRENDA LANDWEHR: This isn't about disrespecting the state employees. These individuals made a personal decision to leave state employment. At that point, our job is done. And to say that we should give them an additional benefit a, just let's tell that everybody out there right now struggling to pay their electric bills, struggling to pay their grocery bills. It's tough out there right now. And every little entity that has the ability to hit the taxpayers, they say it's only a small about., it's only a small about. You understand numbers very well, when I did books, I didn't worry about a $20,000 expense, I worried about that $1,000 or $100, you add that up 50 times, ten times, 25 times, that became a real number. Those were the ones that scared you. This is what's happening to our taxpayers, and I'm an individual that serves those taxpayers in a capacity to protect them is -- it's wrong to hit them with one more expense. And the votes can go how they're going to go, I have a pretty good idea. I just think that it's wrong to ask the taxpayers to pay four someone's personal choice to take early retirement. No one is forced to take early retirement with the state. Thank you.

>> CHAIR PROFFITT: All right. Any other Commissioners, comments, questions?

Any motions, anybody chooses to make?

>> STEVE DECHANT: Yes, Mr. Chair.

>> CHAIR PROFFITT: Is your mic on.

>> STEVE DECHANT: I would be glad to back off and let somebody else.

I think the words to use, I move that we reinitiate the blending of Direct Bill members health insurance with the -- help me out there.

>> JENNIFER FLORY: Active employee.

>> STEVE DECHANT: Active employee pool for cost computation purposes for their health insurance. Effective -- would that be the calendar year.

>> JENNIFER FLORY: Plan year 2024.

>> STEVE DECHANT: Effective plan year 24.

>> CHAIR PROFFITT: Looking at the attorneys and the minute meeting takers to make sure they can use that. We have a motion to reblending into the active employee population. Do we have a second.

>> ANTHONY HENSLEY: I'll second.

>> CHAIR PROFFITT: Commissioner Hensley, have a missed you.

>> ANTHONY HENSLEY: I was going to second the motion.

>> CHAIR PROFFITT: Commissioner Hensley with the second. Any discussion on the motion?

Hearing none.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> BRENDA LANDWEHR: No.

>> CAROLYN McGINN: No.

>> ANTHONY HENSLEY: Aye

>> CHAIR PROFFITT: Motion carries, correct, or do we need four? Chair votes aye. How about that?

Commissioners Landwehr or McGinn, any comments you would like to be reflected in the minutes other than what's stated earlier. Commissioner McGinn.

>> CAROLYN McGINN: I don't have any, thank you.

>> CHAIR PROFFITT: Very good, thank you.

All right, we are moving on to No. 5, which is a discussion possible adoption, should the Commission sow choose, PrudentRx special prescription program. Director Flory has the floor again. She should have had a chair up here.

>> JENNIFER FLORY: Is a specialty drug program. Caremark busy the last year for the prescription drug plan.

We wanted to bring this forward with discussion for the Commission to see if you would be interested. Next slide, Pete.

PrudentRx is an independent company, a third party, and they've partnered with Caremark to provide cost savings on specialty medications utilizing drug manufacturer's copay assistance programs.

So this company works with Caremark. All of our specialty pharmacy program drugs today go through the Caremark specialty pharmacy. Now would be able to be used with all of those. These are the high cost medications. Members would be enrolled in the manufacturer's provided non-needs based copay assistance programs. What we mean by that is there are different types of copay assistance programs. What we are talking about with this program would be the copay assistance programs available to any person who has is purchasing that drug, not based on that individual's income. There are other copay assistance programs which are needs based on income, and they would not be included in this program. This is only the copay assistance that manufacturers are providing to anyone who is using their medications.

PrudentRx would work directly with Caremark specialty to get the members enrolled in the copay assistance programs and we paying this to PrudentRx's fees through this through a shared savings program. We have experience using shared savings programs with blue cross, and their program, which is -- what is the name of that thing? Smart shopper. I have a blind block on that. That's the program where people can go out and see if they if use the low cost provider, they can get a refund check. We do pay a shared savings when individuals use that. That is exactly how PrudentRx would be paid.

So on the next slide, we go over the goals here with this program, which is we are using available resources that are already out there, these are these copay assistance programs, many of our employees use them today, but we would change our specialty medication, we adding a tier to our programs for specialty medication with a 30 percent cost share.

We ideal enroll the members into the copay assistance programs that would be using those manufacturers dollars to pay that coinsurance.

For members the upside is that the member is going to save money because the specialty drugs would be available to them at no cost. That would be a huge, huge change. For our members on Plan A, on Plan C, J, and N, they of to meet their deductible before they see cost savings.

It has been in place for a while with Caremark and PrudentRx, initially when we were learning about it, we had reservations and didn't want to be the first ones to try it. We wanted to get some experience with other groups and so we waited.

But now that it's been around for a while, we thought it was an opportunity we needed to bring

forward to the Commission to see what you thought about it. Next slide, Pete.

To give you a little more context about what we are talking about. What is a specialty medication. Specialty medications -- next slide, Pete. High cost medications used to treat complex and chronic conditions like rheumatoid arthritis, many of them for MS, cancer, they tend -- some of them are for rare conditions. Many of them are biologic medications that are manufactured using some type of biological process or extract from some living source. Some examples that you may be familiar with, Humira, Enbrel. They are used for so many things now, Crohn's. Remicade a cancer drug. Stelara one used for skin disorders, Herceptin is a cancer drug. High cost medications, many of them require special handling, they are self-administered, they could be injectable, infused, oral medications. They may have a limited distribution channel for our members, our distribution channel is Caremark specialty. The specialty medications, this is a big part of when we talk about pharmacy spend, we are talking about a very small number of members who spend more than 50 percent of our prescription drugs. So we have 1.3 percent of the prescriptions that go through our plans are for specialty drugs but account for 57 percent of our specialty spend. That's state dollars right there.

On the next slide, we are looking at the different plans so you can see. Our plan design is different. Plan A, those drugs are not subject to the deductible. And we have a cost tier in our prescription drug program on Plan A that limits the member's cost under the special case tier today at 40 percent of the cost of the medication, 40 percent coinsurance to a cap of $100.

So that's why you see that the state spent almost $35 million and the member cost share of that was only $716,000.

On Plan C, J, and N, members have a deductible to meet their cost is based on the tier the drug falls in, whether it's generic, very few are generic. Most of them are brand name or preferred brands. In this space, there's not a lot of generics, particularly with biologics. We are starting to see bio-similars, that's still a really, really small part of it.

Let's look at on the next slide, how this would work. I'm a Plan A member, they are picking up the majority of the cost of my specialty medication. No are subject to the deductible. That member's responsibility is generally going to be capped at that $100 under the special case tier. The stays is picking up the rest of the cost.

The member cost that $100 they would pay, that does count towards out of pocket.

Just as an FYI, there are no diabetic or asthma drugs in the specialty category. I should have mentioned that.

On the next slide we show you how that would work under PrudentRx system. Under PrudentRx, we would need for the Commission to add a benefit tier for specialty drugs with a 30 percent cost share and with no cap. PrudentRx would go out and work with our employees with Caremark, and we can ask RXSavings to help us as well to get the members enrolled in the nonneeds based copay assistance program.

Then when the member presents their claim to Caremark specialty, it would process through the PrudentRx program, and the member would receive that medication at no cost for their up to 30-day supply of that specialty medication. The copay assistance would be obtained from the manufacturer to pay that 30 percent coinsurance, and then the state would pay the balance

of that medication cost.

The state will benefit because that 30 percent coinsurance is higher than what the state currently is paying with the member only paying $100 of that current cost.

Plan C, J, and N, again, prescription drugs on those programs are all subject to the deductible. Remember because Plan C and N are qualified high deductible health plans, only those items identified in the I.R.S. statutes can be exempt from the deductible. They are all subject to that. Why after that, claims are paid based upon what type of medication it is, whether it's a preferred brand or a nonpreferred brand. Again, we are not going to see many generics in this population.

And the member pays that coinsurance, they share in the cost of that medication with the state by paying that coinsurance, whether it's 35 percent of the cost or 60 percent of the cost. And that member coinsurance that they're paying out of pocket then is applied towards meeting their out of pocket maximum. These folks may be using copay assistance today to help pay down their out of pocket. Any money that's paid by copay assistance does not count towards meeting the members deductible or out of pocket cost because those aren't actual dollars they are spending out of pocket. As a matter of equity, we cannot allow that to count towards those out of pockets because somebody who has had an accident may incur expenses and have to pay 20 percent of their coinsurance cost to the cap. Out of fairness, years ago, it was determined that any money that is paid by the third party on behalf of member does not count towards reaching your out of pocket.

With PrudentRx on the next slide, it will work similar, we need the Commission, a 30 percent coinsurance tier on Plan C, J and N. Subject to the deductible. When the person is enrolled, PrudentRx will get them enrolled in a nonneeds based copay program. After the deductible, Caremark specialty would work to get the 30 percent paid by the manufacturer, the member will pay nothing for their specialty medication, and the state would see that reduction in cost for those members.

So on the next slide, we have what the projected savings would be. Using this program and understanding that we will be having to pay a fee to PrudentRx. So with this program, the total savings is estimated by Caremark and PrudentRx at 5.7 million. Our members will save that 716,000, you'll remember that from earlier, that's the amount they are paying today towards the cost of their specialty drugs.

State would save 3.7 million. And we would be paying a fee to PrudentRx of 1.2 million for this program.

Plan A is where the big savings is. First of all, this is where most of our high cost specialty users live. And second, because the current cap at $100 is very, very low. So the amount of member spend is very limited. And the state is picking up the balance of that cost already.

Plan C on the next page, J and N, the savings much less because we have the deductible that needs to be met first. 886,000 in savings, that is the member cost we identified earlier. The state savings would be 702,000, and we would be paying PrudentRx approximately $234,000 for this program.

So on the next slide, you know, if the Commission is interested in this program, we do have the

opportunity, we could get this in place for plan year 2024. Provide all the communications to members during open enrollment. This would allow us to let members know about the change and particularly those members who have a health care flexible spending account, on Plan A, those amount of that you set aside in your flexible spending account are set during open enrollment. So we would want to communicate this so members could accurately set aside funds if in their flexible spending accounts to reflect the change in the benefits.

The HSA program has a little more flexibility, members can change their HSA contributions throughout the year. So it's a little less disruptive, but if the Commission were interested again, we just wanted to bring this forward, give the Commission a chance to hear about the savings and determine whether they were interested. If not, we don't need to do anything.

With that, mime more than happy to answer questions.

>> CHAIR PROFFITT: Thank you, Director Flory, Commissioner Landwehr.

>> BRENDA LANDWEHR: Is the 1.2 a new expense or would it be a new expense.

>> JENNIFER FLORY: Why are you.

>> BRENDA LANDWEHR: Page 47.

>> CHAIR PROFFITT: The PrudentRx savings and the shared savings.

>> JENNIFER FLORY: That would come out of that 5.7 million in savings. We would be paying that $1.2 million fee. And the state would be saving 3.7. Because of the change from going from an employee only paying $100 for up to a 30-day supply of a specialty medication. The plan design would change to being a 30 percent coinsurance and then we would use the copay assistance we get from the manufacturers to pay that down so that the state spend would be less for those medications resulting in the $5.7 million in savings, which would be shared between the employee, the state and PrudentRx.

>> BRENDA LANDWEHR: Thank you.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: I have a question about the number of manufacturers that offer nonneeds based copay assistance programs. Do all of the manufacturers of the specialty medications off those.

>> JENNIFER FLORY: I can't give you an exact number of how many manufacturers offer them, but as they built the savings model, they took into account the manufacturers that have available copay assistance programs that would be able to be accessed so that the savings would reflect that if there's a medication where there is no copay assistance, the member still will pay zero and we'll use part of the savings to pay for that. That was all included in how Caremark and PrudentRx set up the savings to reflect the availability of copay assistance.

>> CRISTI CAIN: Thank you.

>> CHAIR PROFFITT: I have a question, Director. Quick math, between Plan A and Plan C, J

and N, the projected savings from the vendor would be $4.2 million net benefit to the state across all four plans, 1.6 net benefit to the employees, $1.5 million to PrudentRx. This is a shared savings program. So the state, employee and PrudentRx all share in the savings in the aggregate, not on a script by script basis. Is there a cap? Is it mathematically possible that this could cost any one of the entities more, specifically the state or the employees, I'm less concerned with PrudentRx.

>> JENNIFER FLORY: I'm not sure that I can answer that. But we do have Eileen mine Kay with Segal who is online. Eileen is our pharmacy consult weren't a Segal. She has clients that use this program today. I also should have mentioned we did contact several public entities that use the program today, and we have their reference, it's listed back in the appendix under tab No. C. Eileen, could you maybe speak to that?

Pincay, can you hear me.

>> EILEEN PINCAY: I can comment. What we are seeing for our are our clients that have this in place today, we haven't seen it where it was a negative impact to the client and/or member. I don't foresee that as well. Just to comment earlier about the pharmaceutical manufacturers, one thing to note is that the manufacturers may end up discontinuing their particular program. I would say that CVS has a robust set of manufacturers that they get copay assistance from.

Does that answer your question.

>> CHAIR PROFFITT: Sort of. I think the answer was I haven't seen it to where there's a net cost to either the employee or to the employer. Is there a scenario in which it is mathematically possible whether it could cost more. If so, is there also a cap on the shared savings such that the employer and employee would not take the hit on this.

>> EILEEN PINCAY: I don't see any negative impact to the employer for this type of program. The reason I say that is because they're basing it off on the manufacturer coupons, that's really what's paying for the program itself.

>> JENNIFER FLORY: We have a representative, Caremark here, if you would like to hear from him.

>> CHAIR PROFFITT: Yeah, if you can introduce yourself first, please make sure the microphone is on. Ultimately the question is, what I would not be interested in is adding my level of risk to the state or employee. If we implement this, would PrudentRx ensure a cap so there is no financial impact to the employee or employer.

>> David Locke with CVS. The there is no guarantee that you're asking for, however, it is a shared savings model. So there's no fee if there's no savings. So the only -- so there's not a way to incur extra fees because there's no -- there's no extra fees built in, no fees if there's no savings, there won't be a cost to the state if there is -- if there's no savings. The only possibility I can see, and again we haven't seen this with any of our clients, the only possibility I could see a potential downside would be because you're raising that to 30 percent with no cap, theoretically, because that's the way the question was asked, theoretically, members could see a 30 percent increase, but they're going to see that go down to zero dollars.

So if, for whatever reason, that cap was raised to 30 percent and the state picked up that fee and for some reason several manufacturers pulled out and there were no savings models there, there could be a higher cost to the state and no savings there. However, there is a clause that if manufacturers pull out or if there's a reduced savings, Caremark can terminate to say there's no more savings, manufacturers have pulled out, we'll revert you back to your old benefits and the state has the option to pull out as well within 90 days if you give us notice to say there's no longer savings here because all the manufacturers pulled out. It hasn't happened with any of our clients. I want to answer your theoretical question.

>> CHAIR PROFFITT: I appreciate the honesty, it is theoretically possible, you have not yet seen it. I'm comfortable with that answer. Commissioners any other questions while he's up here tore the Caremark rep.

>> JENNIFER FLORY: Can you tell them how long the program has been in place.

>> 2016.

>> CHAIR PROFFITT: Thank you.

Commissioner Dechant?

>> STEVE DECHANT: I don't know if it's most appropriate for him or another. Is PrudentRx the only entity that does this sort of thing, or is this one of some or several.

>> There are other programs in place through other benefit managers. Director Flory spoke to needs based assistance, which is a totally different ballgame we don't want to get into. Yes, there are other programs similar to this in place with other prescription benefit managers.

>> STEVE DECHANT: But PrudentRx -- I'm sorry.

>> That's okay. I was going to add the other -- CVS's other competitors, at least one of them works with another vendor similar to PrudentRx. As David mentioned, nonneeds based, another vendor that actually looks at that.

>> STEVE DECHANT: So PrudentRx is one of several, at least. And they've been around since 2017 or at least the Caremark relationship with them has been since 2017? 16, okay.

What are the downsides going with -- moving into this? Whether that's from your perspective and you might not see any or staff perspective, what are the downsides.

>> I think the challenges that face is the member communication of we have to make sure to hit the ground running with getting members enrolled. A lot of times we can automatically enroll them in this benefit to make sure that they're signed up for that copay assistance there. Communicating it to them, making sure they understand, a lot of times members will say hear zero dollars what's the catch there. That's the will challenge that gets faced there of making sure that members are aware that they are enrolled. I think the good part of that is that you saw on some of the other slides how many members this impacts, it's only the specialty population there. So I think it's around 900 members in all that are going to need to be enrolled in this. We don't have to communicate to all 65,000 members, just the specialty members taking a specialty medication. If there is a new specialty member that comes along,

we work directly with PrudentRx to send them a daily feed to say, hey, we got a new specialty member, make sure they are enrolled. So they've been doing this a long time, they are really on top of the member communication to make sure those members are enrolled before this even goes live. If it were to be adopted for 2024.

>> STEVE DECHANT: You can't target who -- you can target who you have your correspondence with. Wouldn't be at all 40,000. 1,000.

>> JENNIFER FLORY: We have 1,306 members currently with scripts, you'll see that, it's on page 5 in this packet. That would be involved. So ultimately, from our side, the downside would be is if in the future point in time, manufacturers get away from the copay assistance process, that they currently have, and we had to change our benefit, our members would now be used to be getting these high dollar drugs at no out of pocket cost, there would be some disruptions when you have to go back and implement the Commission would want to look at the 30 percent coinsurance and say, that's quite a lot when the drug is $5,000 for a 30-day supply, and moving that to whatever would be decided at that point in time. Probably would be noisy, you know, it wouldn't be a lot of members disrupted, but it would be a big change for them. So that is a downside.

We initially were a little concerned when they initially rolled this out because we weren't sure what the longevity of the program would be, you know, if we enrolled our members in this and everybody pulled out, that would be disruptive, but we have waited a number of years, and it's continued to be offered and other employers are taking advantage of that savings. So we at least wanted to bring it forward to the Commission so you all got an opportunity to hear about it and make the determination of whether or not you were interested in pursuing it.

>> Just to add on to Jennifer, in regards to considerations, I agree, the manufacturer assistance made up being discontinued, they really can be rescinded at any time. The of the program appear to be high at 25 percent, based on Segal's experience, we do see other vendors charging similar amount of, so I guess we are okay with that. The other thing I'll point out, a critical component of the way PrudentRx determines which specialty drugs are essential health benefits and which ones are not, so there's really no guidance in regards to that approach, but, you know, I believe CVS Caremark is comfortable with that approach. As David and both Jennifer mentioned, if members who do not participate will pay more out of pocket for specialty drugs, than they do under the state's current plan design, so it is possible that the member gets their own specialty copay assistance, but I feel like this doesn't really happen or if it happens, it happens very minimally. The last thing I'll probably call out is the mental health parity act. So for this one -- I always just tell this to my clients. You have to make sure you're not being more restrictive for the mental health use disorder benefits. 36 this program should be reviewed to make sure it doesn't restrict my mental health use disorder drugs improperly.

>> CHAIR PROFFITT: Thank you. Commissioners, any other questions?

Thank you, David, appreciate it.

So that was a lot to take in. New program to the Commission, sounds like maybe not a new program to the marketplace. I leave to it the will of the Commission whether somebody wants to make a motion, have discussion on moving forward with this or say no thanks and move on.

>> CRISTI CAIN: This is Commissioner Kane. I was going to make a comment after reviewing

the references from the state of Kentucky, Texas and Missouri, it looks like they have experienced savings, definitely it looks like issues with the rollout and with communications. I would want to make sure that we try to make that as smooth as possible, if we implement this.

>> CHAIR PROFFITT: Thank you. Commissioner Landwehr.

>> BRENDA LANDWEHR: My concern is not the program itself. I think it's probably a good deal, but as the Commissioner here just mentioned, the other states have had problems with rollout. We are not that far from open enrollment for the state employee plan, I think this is kind of late coming into this. I'd rather see us do due diligence so we don't create a lot of havoc with our state employees, is to definitely review this, lay out a plan, know how we'll roll it out and how do we avoid any of the hiccups and put it into the 25.

>> CHAIR PROFFITT: Any other comments or discussion from Commissioners. Commissioner Dechant.

>> STEVE DECHANT: It does seem almost too good to be true. I picked that up from the comment that David made.

But it does seem to be something well worthwhile to pursue. If it is, why not go ahead and go after it. However, you make good points. I would be interested in hearing from staff, what are your thoughts? Do you feel you'll be rushed if we move to implement this for plan year 2024? If you are, I think we probably ought to wait until we know for sure that we feel confident we can get it out and get it out well. I think we have to, even though it's to 1300 people or whatever the number is, put out some general information. There will be talk. I'm going to wonder why can't I get this great deal when my neighbor is getting this great deal. Granted we target and give the most communication to those who are likely to benefit, but I think we need to give some information to the general population just to let them know it's here and targeted to a certain group of people.

>> CHAIR PROFFITT: Before staff answers, just because outside of this room I have a relationship with staff, as secretary of administration, want to make sure that my biggest concern is shared to not put them in awkward position. When I see what I read was, I could be wrong, PrudentRx would lead the messaging efforts behind this, if they're the experts, I understand that. I'm of the opinion that messaging needs to be at least run through and controlled by state employee health plan and approved and things like that. So I would be very uncomfortable if that was not the case and want to make sure we would have a strong communication plan in place both for open enrollment, if we have time and also throughout the process ensuring we control the messaging and the cadence and timing and content. With that as a backdrop, I don't want to make you say one thing or another. Wanted you to know where my head was at first.

>> JENNIFER FLORY: We would agree. With all of our vendors, we require that communications be approved by staff because we understand our employees and we have worked with them for years and know what works and know what's not going to work. So any communications the vendor would be providing would need to be approved. We would work with Caremark and PrudentRx, again -- one thing that makes this program a little bit easier is that we are not working with a huge number of members, nor are we operating with a huge number of outlets because all of these medications already roll through the specialty pharmacy program at Caremark.

So we have a controlled population, already used to reaching to Caremark specialty, Caremark specialty reaches out to them regularly about their medications, these are medications many of them have side effects, and that if the member doesn't take them properly or timely, they may not be as effective.

So from our perspective, we feel like we do have time to get this rolled out and because it won't take effect until January 1 of 2024, so we have several months to work on it. We also have good partners in that we have both Caremark, we'll have PrudentRx as a new partner and we have RXSavings solution, the pharmacy program consult -- the company that works with our members to help them find low cost medications. They also assist us in these types of programs. They have communication channels already set up with many members to reach out to them about cost savings, and they have experience working with our members.

So using the channels we have available, we feel like we have an opportunity with this small group of 1300 people to be able to communicate the changes that are coming. Will we still have the person who says I didn't know? Yeah, because that happens to us no matter what we do. We can send 1200 e-mails, if you don't read them, that's still a possibility. But we do feel like there is adequate time to be able to communicate this. We would be able to put information in the open enrollment book, we'll be able to include this in the HR training that's going to occur mid-September. We can include this as part of our open enrollment communications and our slides that we use during trainings during the month of October. We'll be sending out newsletters that we can highlight this information in and we can do direct working with Caremark and RX Savings to the directly affected people. We do think there's time to get this done.

>> CHAIR PROFFITT: Any other Commissioners. Questions, comments?

Commissioner Landwehr.

>> BRENDA LANDWEHR: Do we know what the rollout problems were for the other states.

>> Yeah. Paul Roberts, senior manager of operations for the state employee health plan. One of the things I spoke with one of the states that had some of those issues, one of the things they struggled with was they did not have an exclusive specialty program. We do. So as Jennifer mentioned, we have a captive group that we know exactly where to funnel things through. They had an open specialty and they created some of their own issues in communication.

Our people are kind of already set up and guided directly through Caremark specialty now. So it makes it much easier for us to be able to target these 1300 people pretty easily.

>> BRENDA LANDWEHR: These drugs are a limited number of drugs, not like drugs all over the place, it's these specialty drugs.

>> JENNIFER FLORY: Correct. Only for specialty drugs that come from the specialty pharmacy.

>> BRENDA LANDWEHR: Thank you.

>> CHAIR PROFFITT: All right, Commissioners. We are at that point. Again, options are unlimited, I suppose. But we can either move forward with implementing this in plan year 24, we can talk about pushing to 25 and developing a more comprehensive plan and bringing this up at the first quarter meeting or we can just stay silent on this and move to the next topic and this goes nowhere. Open to the will of the Commission. Commissioner Cain.

>> CRISTI CAIN: I will make a motion to create a specialty drug benefit tier with a 30 percent cost share with no dollar cap and to implement the PrudentRx program.

>> CHAIR PROFFITT: Effective.

>> CRISTI CAIN: Effective plan year 2024.

>> CHAIR PROFFITT: Okay. Is there a second.

>> STEVE DECHANT: Second.

>> CHAIR PROFFITT: Discussion?

Commissioner Landwehr.

>> BRENDA LANDWEHR: Is there -- okay, there's no cap, could this then end up increasing our cost on this program if there's no cap. We know that the price of drugs fluctuates on a regular basis.

>> JENNIFER FLORY: So what she is referencing, the 30 percent coinsurance with no cap. Currently on Plan A, an employee cost is capped at a maximum of $100 for up to a 30-day supply. This new coverage tier would be the member coinsurance would be 30 percent and there would not be a limit. It would not be on the state side of the house, it's on the employee's share that we are talking about having no cap.

>> BRENDA LANDWEHR: Thank you.

>> CHAIR PROFFITT: Any other discussion. Members online, any discussion?

Hearing none, before we move forward to a vote, if this moves forward, my expectation from the vendor would be to be present at all HCC meetings in 2024 to report on the program, whether it's virtual or in person to make sure we are reporting throughout and what the rollout is and if there are hiccups, if there are any, I expect an e-mail so we can address it in realtime.

I'm getting a head nod back there, they are agreeable to that.

I think I heard a 90-day exit, termination clause with this, if something goes on?

Okay.

Do we have flexibility to make that 60 or is that a contract discussion? 90 feels like a long time. Feels like a long time if there's a problem with the program.

>> JENNIFER FLORY: Trying to do a mid-year change is always going to be a problem

because you're going to be moving members mid-year. I believe the standard provision that they are provided within the contract, which we submitted for review with our legal team was the 90 days. I don't know if we have flexibility to do 60.

>> CHAIR PROFFITT: David.

>> JENNIFER FLORY: I leave that to Caremark to address.

>> I can't speak to what the legal department would allow at this point. However, we have always negotiated on contracts. We are certainly open to questions and red lines as the department sees fit.

>> CHAIR PROFFITT: Very good. Just full disclosure, should this move forward, I would be pushing for a 60-day termination clause rather than 90 to protect the interests of the state. Want to be clear with that. Understood.

Thank you.

Okay. All righty. We will go through a vote.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> BRENDA LANDWEHR: Aye.

>> CAROLYN McGINN: Aye.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: Motion carries. Thank you.

All righty. On to agenda No. 6, we are going to discuss plan year 24 open enrollment. Director Flory, I'm assuming that's you.

>> JENNIFER FLORY: I'm going to defer to the EAC president to let him give his report because this was discussed at their meeting yesterday.

>> CHAIR PROFFITT: Back up.

>> SCOTT SHOWALTER: I'm back up. All right. We discussed it, we had a number of people who had worked within the system and it was determined that because of the substantial number of people who would have to be active anyway, if they had opted into a number of the different programs, and since the state employees have been in an active system for the last five or six years, that we felt like any modification or changeover to the pass I would probably cause more harm than good, and under those circumstances, we determined to ask that you remain active and any employee would have to go through and actively choose the selections on his plan.

>> CHAIR PROFFITT: Very good. The recommendation is to renew with active enrollment as

we have in the last several years.

>> SCOTT SHOWALTER: That's correct.

>> CHAIR PROFFITT: Questions for EAC?

Hearing none, getting off easy today.

Director.

>> JENNIFER FLORY: So Pete, let's move forward. As you just heard, we have had active enrollment for the last six consecutive years where employees enrolled in the medical insurance had to actually go out and complete an enrollment in our membership administrative portal. If they failed to do so during the month of October, which is our open enrollment period, they would be defaulted to Plan N with a health reimbursement account.

Plan N is a quality health insurance program, it is not a penalty to be defaulted to Plan N, it is a quality insurance product, but it is our least expensive product, and so that is why we use that as a default because we wouldn't want to default people into a higher costing program. So that's why the quality of N.

As we think about, this is a topic that had come up last year prior to open enrollment with the Health Care Commission. Did they want to continue to have active enrollment or move to a passive enrollment? The response was we need more information. So we had gathered information during this last open enrollment for plan year 2023. So we wanted to bring this topic back for you all to consider since it's one we have been talking about for a while.

As we have some changes in plan year 2024 and there are some plans that we offer that we require an annual enrollment, the first one being flexible spending accounts, those do require under I.R.S. guidelines members must go in each year and elect to enroll in a flexible spending account. On a future slide, we'll go into more detail about what those include. They allow members to set aside money pretax into an account that they can then use to pay for eligible expenses.

Members do have to elect those each year and they have to set the amount that they're going to set aside during that open enrollment and that amount cannot change during the year.

We also have over 50 percent of our population is in a qualified high deductible health plan. The vast majority of those have elected to enroll in a health savings account. We would not want to have members health savings account amount of change -- not change during the year. We want them to go in and look at those and decide what works best for them and their family. They have to make that election each year to decide how much they want to set aside.

In Plan C, they must set aside at least $25 in order to get the employer contribution. Plan N, there is no such requirement. So some employees may elect to choose not to contribute to an HSA. We need them to go out and tell us what they want taken out of their check, because it is their money and going into their personal health savings account, which is a bank account they own and control.

Our voluntary benefits program, the Health Care Commission elected to move to a November,

going to MetLife next year. They offer hospital indemnity, accidental injury coverage, critical illness plans. This has been very popular with employees, these different options, and we do have a new vendor, they have some slight differences in the benefits mostly enhancements and do offer lower premiums. We would want the member to decide, these are optional plans that they choose. Finally, we have the HealthyKids program, healthy kids, it is the plan we after to families otherwise eligible for the CHP program. That put in place long before the state employee health plan members were eligible to participate in CHP. It continues to be one some employees elect to use rather than enrolling their kids in the CHP program. We'll talk more on the next slides about how many people we are talking about. But that does require an annual election because we need to verify income in order to qualify for the healthy kids program. Moving forward, to look at voluntary insurance programs, we do have over 31,000 contracts in the voluntary insurance products. A member may have one or more of these different options. Again, these folks would need to go out and make an election during open enrollment. On the next slide, we show you, I believe, flexibility spending account programs. The medical flexible spending account is available on Plan A or Plan J. You can get it on Plan C or N if you are enrolled in an HRA. You cannot have a medical flexible account if you have a health savings act. Because you work. Them commuter benefit was brand new last year. It lets employees set aside money to pay for private parking expenses they may be incurring as well as any mass transit experience they may have. Particularly like state pools are available under the mass transit to set aside money to pay your cost for those.

Our health savings account, we have almost 17,000 employees who are enrolled in a health savings account. Those individuals do have to go out and elect how much they want to set aside each year. Next slide.

Healthykids, these are the families that would otherwise qualify for the CHP. 683 enrolled covering 1700 children. This is an option they can elect. That's how many of them have elected to do that, as opposed to putting their children in the CHP program. Next slide.

As we look at the enrollment, and one of the things you had asked us about, how much movement is there between the medical plans? So last year, Plan A saw an increase of 1,585 new members. Plan C saw 1,371 new members. Plan J had 99. And Plan N had 750 moved to that plan during open enrollment last year.

We don't see as much movement between the carriers on the next slide we show you. We had 250 people who elected to go from Aetna to blue cross, and we have 328 who went from Blue Cross Aetna last year during open enrollment.

Next slide.

So currently if an employee does not actively go out and they are currently enrolled in medical insurance, and that's the key, they have to be enrolled in one of our active employee medical plans, they are required today to go out and pick a plan in plan year 23. We had 551 employees that did not go out and make that election of a health plan. Of those 497 were state employees, 54 of them were one of our nonstate employee partners, of that group that got defaulted to Plan N with an HRA, 161 of them already were in Plan A. They didn't actually move.

Next slide.

So we were wanting to get a sense from the Commission, this is a topic we have been talking about over the last year about whether or not you wanted to continue to have an active enrollment for plan year 24. On the last slide, just to remind you, with the passive enrollment, individuals that do not have medical insurance today, they are only enrolled in the dental or vision, they automatically roll forward regardless of the decision on whether we have an active enrollment. If you are waived coverage today, whether we have active or passive enrollment, you would be waived next year. We do ask that employees if they want coverage must go in and actively select it. We will not give them coverage unless they so choose it.

So those individuals would roll forward regardless of the decision, but we just wanted to bring this back and let the Commission decide whether you want to continue to have the active enrollment or whether you're interested in passive enrollment.

>> CHAIR PROFFITT: Very good. Thank you for the overview. Commissioners, any questions, comments, concerns?

Commissioner Landwehr.

>> BRENDA LANDWEHR: Just a question on the last issue you brought up. That doesn't occur if an employee does not renew their insurance, is that correct.

>> JENNIFER FLORY: An employee who has medical insurance coverage today must -- if they don't want to have insurance coverage next year would need to do an active enrollment.

We would automatically provide coverage to someone who has medical insurance today. They would be moved to Plan N with an HRA.

Is that what you're asking.

>> BRENDA LANDWEHR: We can talk about it afterwards.

>> JENNIFER FLORY: Okay.

>> CHAIR PROFFITT: Any other questions from Commissioners. Commissioners online?

Okay, at this point, Commission, two choices, we need to make a motion to either continue with active enrollment for plan year 24 or make a motion to move to passive enrollment. I do have a motion? I would be happy to make a motion if that would make folks more comfortable.

>> STEVE DECHANT: Just avoiding it since I was the active motion-maker.

>> BRENDA LANDWEHR: You were doing a great job!

>> BRENDA LANDWEHR: I'm doing all the talking today. I'm not really comfortable with the passive enrollment. I kind of like the active enrollment, because I think the passive can create problems down the road. So are we entertaining a motion for either or.

>> CHAIR PROFFITT: Correct.

>> BRENDA LANDWEHR: I would be happy to make the motion. I think Commissioner

Dechant ought to second me just because that we do the active enrollment, not the passive.

>> STEVE DECHANT: Second.

>> CHAIR PROFFITT: A motion promise Commissioner Landwehr for plan year 24, second by Commissioner Dechant. Any discussion on the motion?

If for hearing none.

>> STEVE DECHANT: Aye.

>> CRISTI CAIN: Aye.

>> BRENDA LANDWEHR: Aye.

>> CAROLYN McGINN: Aye.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: Motion carries.

>> STEVE DECHANT: Have to have a little fun, don't we.

>> CHAIR PROFFITT: We do, this is enjoyable.

Motion carries, we will pursue active enrollment for plan year 24 again. Staff will get moving on that right away to include education around PrudentRx.

All right, Commissioners, I believe that is the end of the action items. We do have some materials left. We'll move into the report section. We'll begin with our friends from Segal to give a financial report. Come up, make sure you have a blue light and introduce yourself if you could.

>> Patrick Klein with Segal. We'll do the actuarial report right now.

>> CHAIR PROFFITT: Fresh coffee up here.

>> Patrick Klein: Next page, please.

All right, so the first page here, same series of slides -- exhibits that we show normally. This is our year to date, January 2023 through June. We are remarkably right on track with all our projections. We are about $2.9 million better off than we projected. Most of that comes from the revenue of $3.4 million. Small loss of 0.7 million on the program expenses.

So you will note that the table here, there's a little discrepancy between what you say in the variance report at the end, and that's because of that first bullet in the table. We did have two claims payments that were June payments that got pushed to early July. So just to make sure that our budget actuals were a true comparison, we moved those over, but they actually were paid July 5. Any questions about that?

Next page.

So here's the enrollment section, part of the reason why our revenue is higher, we have more people. So .4 percent in total from the beginning of the year to what we have actually seen from January to June. This is kind of a change in what we have seen historically where, you know, typically we have head count at the beginning of the year and trails off slightly throughout the course of the year. Now we are actually seeing an uptick, which it's been the first time in a long time. And then the table below there is a snapshot of the current enrollment as of June 2023.

Move to the next slide, please.

This is our multi-year projection. So we have 2023 where originally we were projecting $72 million, and now that's at 74.1. We are really close to that initial projection. We are within .4 of the total program expenses. Some of the small changes within the underlying projections, medical is a little bit lower because of emerging experience, pharmacy is up and dentals remain relatively flat.

We did get notice that the investment return assumption was to change, and it's almost 2 percent higher per year. So that's helping increase the funds 4.9 million through the life of the projection.

I think those are kind of the key points on that page. Move to the next.

All right, so we have locked in all the decisions that were made in the last meeting, plan designs and the funding. So we are locked in through 2025, the 5 percent employer funding increase, and then leaving the employee at 0 percent. So we are solving for those last two years of 4.6 percent, and that gets us to balance back to the target reserve. That 4.6 is the exact same percentage that was calculated at the June meeting after all the decisions were made.

So this would change a little bit based on some of the decisions made today. The direct bill would have increased this .3 percent. But then the coupon program will offset that and actually a little bit more savings.

So could anticipate that 4.6 going down just a slight bit.

Any questions on that? I'll move to the next page. This is just our sensitivity analysis, I wouldn't spend much time here. It's the same exhibit as normal. It's what our expected trend would look like, that red line and then the fund balance, how it changes if we had 2 percent better trend or 2 percent worse trend, you can see how that deviates from the expected.

That's everything I wanted to cover. Take any questions that you guys have.

>> CHAIR PROFFITT: Any questions, Commissioners?

Commissioner Dechant.

>> STEVE DECHANT: I'm curious about the employee uptick. I'm familiar with corrections to some extent, even though retired from corrections, I don't know.

>> BRENDA LANDWEHR: Need to use your microphone.

>> STEVE DECHANT: My apologies. My question was about the uptick in the number of employees that was mentioned, I know it's not a question for Segal. Just curious, and comments that I'm familiar somewhat yet with corrections, and -- which has been terribly -- struggling terribly with understaffing. Does anybody in the room have an idea of what's happening in the uptick that seems to be going against the grain of what normally happens in the course of a year.

>> JENNIFER FLORY: I do not.

>> CHAIR PROFFITT: I think that's a good question and something we can come back to the next meeting with more information.

>> STEVE DECHANT: Germain to HCC particularly.

>> CHAIR PROFFITT: We can do some research. I don't think anybody would have that information today. In the corrections population, not having the massive declines in employee count, but maybe stabilized. I don't know if that's what's driving this. It could be, but reel research what we can and see what we can come back to in December.

>> STEVE DECHANT: Thanks.

>> CHAIR PROFFITT: Tough topic indeed. Any other questions for Segal?

Thank you.

All right. I have on here as the next report from the EAC, we have heard from the EAC a couple of times. Anything additional to provide or was that the report, effectively those two recommendations.

>> SCOTT SHOWALTER: That was the -- that's the most -- [off microphone]

The committee discussed hearing aids, the process, and -- [off microphone]

To have.

>> Needs to use their microphone.

>> CHAIR PROFFITT: Is your microphone blue.

>> SCOTT SHOWALTER: At any rate, the -- at any rate, there it is. Not only do we appreciate all the efforts you put into the hearing aid, but we have gone ahead and selected subcommittees for membership and for reviewing the bylaws. With that, we will have a meeting in November and not much else to report at this time.

>> CHAIR PROFFITT: Thank you. I know I asked last time if you could provide a written report prior to the meetings, I understand you just met yesterday. Understand why there was no written report today. If you could turn that into staff as quickly as possible so we can read

that before the next meeting, that would be helpful.

>> SCOTT SHOWALTER: That's part of the reason we set it the week before the next meeting.

>> CHAIR PROFFITT: Very good.

All righty. All right, Commissioners, we have made it through the action items and the reports. A few items of note in the appendix. Do you want to draw the Commission's attention to appendix A, tab 9 in your book. During the last meeting, staff had presented a and multitude of options for the 2024 meeting dates. I have not received any -- excuse me, e-mails about requested meeting dates from the options presented, I don't know if staff has. I'm getting head shakes no. I've taken the liberty to circle the dates I would like to get on the books for 2024. I have looked at the legislative calendar from 2023 to try to line that up. So for the February meeting, I would like to target option 3, which is Friday, February 16, and target the 9:30 session. The reason I chose that because the week before, there are some committee deadlines, the week after turn-around day. I want to make sure we are cognizant of the legislative members schedules. Friday, February 1:69:30 to 11:30 in this room. On the time frame, Monday, April 1 at 9:30 would be my recommendation. I will note that Easter is the day before, it's March 31 in 2024. So if anybody has concerns about that, please let me know offline and we can adjust. June meeting, we would like to target Monday, June 3 at 9:00 in this room.

Lord help us if the legislature is still going on June 3. With respect to my legislative colleagues. For the August meeting, we'll target Tuesday, August 20, which would be just -- it would be a year from now at 9:30. The and for the December meeting, Tuesday, December 10 at 9:30.

So I'll make sure I connect with staff after this so they have that reflected in the minutes. We'll get that around to the Commissioners. Obviously we can be flexible. My commitment when I came in January, making sure we are operating one year in advance, wanted to make sure we have that on the books so folks can start planning around.

A couple of other appendix materials in there. Appendix B follow-up items from the June meeting, Appendix C, public sector references. Appendix D hearing aid benefit description, c and f related to the dental program. Before I request a motion to adjourn, any questions, comments, anything on the appendices. Commissioner Landwehr.

>> BRENDA LANDWEHR: Going back to the discussion on the hearing aids, which I did make the second for it, I understand the need, but there's some concerns because we have to keep in mind that the state employee plan is also used to sometimes test out potential mandates on the private sector insurance market.

In my research, I'll give just a little bit of a history on the rules of the federal essential health benefits rules, as they apply to Kansas small and large employer groups.

The state health care commission can change the benefits of state employees health plan and even add dollar and time limits onto new and additional benefits without affecting small and large group policies. Unless the insurance Commissioner determines that the current BCBSKS small group market plan is no longer to be the standard and instead chooses to

make the plan the new EHB standard. Private sector employees would be impacted by the generally more generous benefits and corresponding higher cost of such a plan the earliest could take effect is 2025.

In addition, if the Commission increases the benefits but applies dollar amount of or time limits on those benefits, that has no effect on the private sector plan. Subject to the federal rules, unless the Commissioner changes the -- the insurance Commissioner, changes the standard from the Blue Cross policy to the new ship policy. However, the private sector cannot place the dollar and time limits on any of the EHB benefits like the state does. Why we are kind of special on how our plan works.

In short, it is not the changes to the ship themselves that creates a greater cost problem for the private sector. It's the increased cost combined with the change by the Insurance Commissioner of the EHB standards from Blue Cross model to the SHP model. None of the dollar or time benefit limits would apply to the private sector.

So two questions that I have is the -- I wish that Commissioner Vicki Schmidt was here today. I wanted to ask her these questions, I thought it was important for us to get this on the record so we can pay attention as a member of the legislature, I also, you know, approach this of what has gone on in the legislature, what we have agreed to and what we have disagreed to and the hearing aid one happens to be one we have opposed for many, many years.

So there's a concern that this gets a camel's nose under the tent.

The questions I would have of the Commissioner is the Commissioner aware if she changes the EHB standard to the revised SHP policy that federal law and regulations will not allow employers, large and small to have the same dollar time limits as SHP. Is the Commissioner planning to make a change in the EHB designation to the SHP policy which is a big shift for everybody to make.

If she does plan to make changes the EHB model, would the Commissioner be planning to bring the stakeholders, employers, providers, insurers, et cetera, together for the input for before selecting a new policy as was done years ago. And I felt it was important for us to kind of keep this in mind to get this issue on the record. I know that even though the Commissioner -- insurance Commissioner could not be here today. I'm sure she has somebody monitoring this. I look forward to hearing from her. I do thank you for giving me the opportunity to make those points. One other point I want to make is I was pleasantly pleased to see the detail that was given, explaining the early retirement benefit change, the history so that gave us something to really understand.

You know, it's a communication issue we dealt with last year, Mr. Chairman, of us asking for more information and something as legislators we are used to getting that. I wanted to thank them, that was really great to have.

I do have another -- one request, and this isn't a rush, if it's a time consuming deal, we can get it whenever. I would like to see the history of the amount an employee has been paying over the last 15 years, versus the employer, I'll get it out, has paid over the last 15 years, a history of how that looks so that we can see what shifts have occurred and haven't occurred. So thank you very much.

>> CHAIR PROFFITT: Thank you, Commissioner, we will do our level best to reflect your remarks in the minutes. The Commissioner -- that would be helpful if you could e-mail specifically the questions. I know the Commissioner has staff here, I don't want to put them on the spot and have them speak for her. We can allow the two of you to follow that up offline.

Commissioner Cain.

>> CRISTI CAIN: I wanted to request an agenda item for our December meeting, and that is a review of the employee assistance program.

I would like to know what services are available in the contract and then my outcomes we have from the employee assistance program. So, for example, I would be interested in knowing the numbers of people accessing the programs and if there have been like any satisfaction surveys, obviously de-identified information, but I think it would be helpful just given the research that is showing the significant increase in mental health issues. Especially among -- I work at Kansas Department of Health and environment and public health employees have a higher rate due to working in the pandemic, and so I would be curious to just get more information about the EAP and review those outcomes.

>> JENNIFER FLORY: We can bring back information about the contract we have with our current vendor. There are two components, the employee assistance program that falls within the Health Care Commission, but within that RFP we put out, we include benefits that are part of the Office of Personnel services, that they use for training and some critical incidents and a variety of things. I will not have information on that. So I'm assuming you're asking us to provide the information on our share of that, which is the eight visits at no cost, and the other programs, the legal assistance and financial assistance and the variety of programming through that part, correct.

>> CRISTI CAIN: Yes.

>> JENNIFER FLORY: We can do that.

>> CHAIR PROFFITT: Thank you for the request in advance, we will bring that back, I think it is critical we review any progress against the programs we have in place, appreciate the insight there.

All right, Commissioners, any other last-minute requests?

Comments, concerns? Side remarks?

All right, I would welcome a motion to adjourn.

>> STEVE DECHANT: So moved.

>> CHAIR PROFFITT: Is there a second. Any opposed?

We are adjourned. Thank you.