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KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION
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>> CHAIR PROFFITT: 1:33 on Tuesday, April 9.
Welcome, everybody to the health care commission meeting, appreciate your being here, either virtually or in person.
Also appreciate director Conroy and the entire kpers staff hosting us here in the room.
Nice to have an official place of business, especially with the spread they provide.
Appreciate their willingness to accommodate us.
We'll go ahead and take roll.
I know at least one of our legislative friends is planning to join virtually, I think the other one might be as well.
With that, I'll note who is in the room.
Commissioner Schmidt, Dechant, Commissioner Cain, Hensley and the chair.
Commission McGinn, are you online?

not seeing and not hearing.
Commissioner Landwehr, are you on online?

>> BRENDA LANDWEHR: Yes.

>> CHAIR PROFFITT: All right.
First order of business is item 1 in your book, the approval of minutes from February 16.
This material should have been sent to the commission last week.
Any updates?

>> STEVE DECHANT: I move the minutes be approved as presented.

>> CHAIR PROFFITT: Is your mic on, Commissioner?

>> STEVE DECHANT: yes

>> CRISTI CAIN: This is Commissioner Cain, I'll second

>> CHAIR PROFFITT: Any discussion or conversation.
Hearing none, all in favor say "aye."

[chorus of ayes]

Any opposed, minutes are approved.
All righty.
We'll move on to tab 2 in our books, Commissioners, we have a few RFP's to get through today.
We'll start with the dental plan administration contract.
And I believe director Flory will walk us through this.
If we can get to that slide on the virtual screen.
We can get moving.
Director?

>> JENNIFER FLORY: Move to the next one, Pete.
The dental benefit, our dental plan is a self funded plan and we hire a third party administrator that provides services such as a network, they provide the dental benefits to our employees that include diagnostic, preventive services, as well as basic and major restorative services, orthodontia and implant coverage.
On the next slide.
The contract we currently have with Delta Dental expires on December 31.
We did release a new RFP.
Currently we have under our dental contract approximately 46,000 covered employees and their families under the self funded plan.
Segal was asked to assist in the review of this RFP by evaluating the financial components.
This included a repricing exercise based upon our actual claim file experience.
The vendors do sign a confidentiality agreement in order to participate in the repricing agreement.
And it looks at their fees, their discounts, their network penetration and the cost impact to both the self funded plan as well as to the members.
Our proposals assume a start date of January 1, 2025.
Next slide, Pete.

We did receive three bids, Blue Cross Blue Shield of Kansas, Delta Dental of Kansas and Skygen U.S.A. All three vendors were invited to finalists meetings where we reviewed their information and had a discussion about their bids and their pricing.
Next slide.
We looked at their capacity to administer our program, the breadth of their network, claims processing, the customer service they would be providing to both the members as well as to the plan, as well as their reporting capabilities.
Next slide.

Services included include that network claims administrating, reporting, they do have to have a member portal.
Portal for the State Employee Health Plan.
They provide member communications, id cards and benefit booklets.

and this is our famous KDOT map.
We show this to remind you of the areas, we do divide the state into six areas to review the network cuz it allows us to better see the vendor’s penetration than say using geoaccess which can be very distorted, particularly in a rural area.
As we look at the networks on the next slide, you'll see that Blue Cross has a wide network, as does Delta Dental and Skygen is a new vendor and they rent their network and you can see it is significantly smaller than the other two.
Both Blue Cross and Delta offer a ppo network, as well as then a premiere network.
The premiere is a larger network.
The ppo tends to be the discount network.
They offer both of those.
Skygen does not offer two networks, they only have the one.

Next slide
In looking at the fees that they have bid, they bid a per employee per month administrative fee.
You'll notice that Skygen's fee is higher. Part of that is because they are renting that network.
As well as the fact they would be charging us a fee for implementation.
So that's why you'll notice that their fee does differ.
You can see the fee on a monthly, annual and three year basis shown on the slides.
This does assume the contract for 25, 26 and 2027.

next slide.

some additional costs that we always like to know and find out, what kind of programming fees we might be charged and what would be the fees to obtain files into our data warehouse, what if we need to modify those file layouts to obtain additional information.
So each one of the vendors did provide a response on what fees they might charge for those additional services.
Next slide.

We asked them about what credits, it isn't uncommon for a new vendor to offer a credit to the plan that we can use to help offset costs should the plan be moving to a new vendor.
There are costs inherent in doing that.
Blue Cross is offering us a $200,000 implementation credit.
Delta Dental is our current vendor.
There would be no implementation and Skygen did not include one.
Delta has offered $5,000 credit to use towards the cost of member communications, such as we do a video for our website on each one of the plans and that money could be used to produce that feed that explains the coverage of our dental program.

On the next slide, this is the slide that Segal helped put together that shows a summary of the evaluation of the discounts available based upon that claims review.
The second bullet point shows you again the fees for that annual administrative cost we would pay.
And then other projected costs, and that is footnoted there at the bottom of the slide on Blue Cross.
That there are some fees that would be associated with that particular bid.

and then the total three year projected cost.
Now, you'll notice here that when you look at Skygen, their total projected cost is lower, that is because their network is significantly smaller and as a result, more of the claims are going to land in the nonnetwork bucket, and that's going to push additional expense onto employees.
So that is one of the reason why you'll see that cost there is smaller.

Gina, did you have anything you would like to add on this slide?
If you'd go to the mic.

>> GINA SANDER: I think you did a good job of explaining it.

>> CHAIR PROFFITT: If you can introduce yourself.

>> GINA SANDER: I'm Gina Sander with Segal.

>> JENNIFER FLORY: Does anyone have any questions for Gina while we are on this slide?

>> CHAIR PROFFITT: I think it might be helpful to round out the next two slides and come back for questions.

>> JENNIFER FLORY: So we on the next slide, Gina had put together some information on the impacts of the balance billing and I'll let Gina explain this one.

>> GINA SANDER: When providers are asked to join a network they agree to a certain set of reimbursements, whether it's a fee schedule or discount off eligible charges.
And if they don't want to join the network, they don't agree to those charges.
So when a provider is in the network and a member goes to that provider, they have agreed to accept the reimbursement for that level of benefit and there is no balance billing.
If they are not in the network, then the provider will bill the additional amount between what he is reimbursed, which is usually and clearly here at a lower level, in this case with Skygen, they used one of their fee schedules as the basis for reimbursing the providers from one of their networks as their reimbursement basis.
And it's a low reimbursement level.
So there's a good amount of space between the submitted eligible charges and what they get reimbursed.
that will get balance billed to the member.
So that's why you see the cost to the plan being low because they have a lot of out of network providers being reimbursed at a low level.

And then that extra additional balance billing has the potential to be passed on to the member.
And that is at each provider's discretion.

you want the next slide?
Sure.
We'll go to the next slide, page 23.
So this illustrates the potential exposure to balance billing that would occur with each of these vendors.
And Blue Cross Blue Shield and Delta Dental have a significant network so there's very little balance billing being passed on, but Skygen has so few providers in the state, there's the potential for additional balance billing.
And you see you see the bottom line here where it shows the network utilization mix, which is the percentage of claims flowing through in network providers versus out of network providers.

>> CHAIR PROFFITT: Thank you for that.
So just to make sure I'm clear, if we kind of if we only looked at page 21, we would be seeing what we feel would be the cost to the plan based on network providers.
Because there's a large potential for large balance billing passed onto your our members to get the true cost across the entire the of the plan, we would add 21 and 23 together, is that a way of thinking of it.
21 is what we expect the plan to be.

>> GINA SANDER: That would be a worst case scenario.
It would be at the discretion of the vendor.
But even if 50 percent of them decided not to pass along the cost, you would have a huge amount passed along.

>> CHAIR PROFFITT: If we added those numbers page 21 is not representative of the total cost of dental in Kansas, specific to Skygen.

>> GINA SANDER: This is plan paid cost on page 21.

>> CHAIR PROFFITT: Thank you.
Commissioners, any questions about anything in this portion.

>> STEVE DECHANT: I have one.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: The projected cost for any of the providers, but especially for Skygen, how did you come up with on page 23, how did you come up with those?

>> GINA SANDER: We used the projections for your current dental projections based on your current experience and applied the results from the repricing analysis, which also indicated to us how much of the claim dollars were flowing through providers that were in network versus out of network.

So we took your experience, we applied the discount information to your experience for Blue Cross, for Delta and for Skygen and because Skygen has so few providers the application of the discounts went to a much lower percentage of your claims impacted this is the difference from what your baseline discounts are now.

So the out of network piece of this, they had estimated how much it flows through, how much the plan would pay for out of network, which was very much lower because of the lower reimbursement.
So there's much fewer claims flowing through out of network providers for Blue Cross and Delta dental.
They reimburse at a low dollar amount also.
Because most of their dollars flow through providers in network, you're not getting the lower reimbursements to the providers.
Whereas Skygen has the lower.
So you'd get more member noise because they would have a more difficult time finding a provider that's in the network.

>> STEVE DECHANT: Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you mister chairman. I want to go back to page 14. On that, it's a bid evaluation page.
And so the information we have in our packets today address the vendor network, and address a little bit of the claims processing, but only in the dollar amount, not in the like claims and trouble.
Is there any type of I mean, it says the bid was evaluated on these six things.
On the remaining four or five things, like capacity to administer the program, are those the same for all three, are those different, customer service from members, do we have feedback from our members on have they had issues with the current vendor, services to SEHP staff, has what are these other boxes mean because we don't really have any information about the bids on these other boxes.

>> CHAIR PROFFITT: Director Flory, is there any high level anecdotes or data you can provide.

>> JENNIFER FLORY: The vendors are requested to answer questions regarding all of those things.
We require certain customer service hours, we ask questions about turnover in customer service and ask them questions about their claims administration capacity, what percentage of that is electronic versus paper.
We ask about their error rates.
We ask them about a variety of different things around claims.
We get sample reports within the RFP.
We look at those as well.
With our current vendor, we have a very low amount of member questions or concerns that come into our office.
They have been our partner for a number of years, and we don't receive a great deal of member concern about their handles of dental services, staff has a good working relationship with them.
They submit their billings timely.

They submit their performance guarantees timely, so we do evaluate those things that are listed in the boxes.

>> CHAIR PROFFITT: Is it fair to say that some of the larger differences are what make the packet in here as it relates to what the commission might be voting on, knowing that some of that might be subjective in the eyes of the commission, but as it relates to the other four boxes, most of them are largely meeting the objectives set forth by the RFP?

>> JENNIFER FLORY: Yes.

>> CHAIR PROFFITT: Thank you.
Commissioner Schmidt?

>> VICKI SCHMIDT: Then on the page 16, KDOT map, so to speak, is there a key to that?
I don't have any idea what those dots mean?

>> JENNIFER FLORY: Those are just cities within those counties.
Difference in the blue and green dots.
Like I said, we use it more as a regional map.
So we are looking at the big picture, the big colored areas like the one, two, three, four and five six, to divide the state up.
It gives us a way to better visualize our membership and when you look in on the next page, you can see we have told you how many employees we have and then what the network access in that given area is.

so it's just a way we have used we found works well to divide the state up and be able to visualize member access.

>> VICKI SCHMIDT: I thought maybe the blue dots since the next page had Blue Cross & Blue Shield as blue and Delta dental as green, I thought that related to that because there's no key or anything on that.

>> JENNIFER FLORY: It's a k kdot map.
We use it for the large colored chunks as opposed to the individual city information.

>> VICKI SCHMIDT: Mr. Chairman, on page 18 where it says the PEPM administration fee for each of the three companies includes network access and will remain flat, what does that mean that the administration fee includes network access?

>> GINA SANDER: These administration fees include network access fees and Skygen said they will roll their implementation charge into that fee also.
But Blue Cross and Delta own their networks so there's not there's not a network access fee, but Skygen leases their networks, and there is a network access fee in their pricing.

>> VICKI SCHMIDT: So maybe that should have said the administration fee for Skygen includes network access because the other two don't include network access?

>> GINA SANDER: They didn't specifically list it out separately and Skygen did.

>> VICKI SCHMIDT: Okay.
Because that makes me think   anyway, okay, thank you.

>> CHAIR PROFFITT: Any other questions?

Commissioner Landwehr, want to make sure you have an opportunity in case I'm not hearing you.

>> BRENDA LANDWEHR: I'm fine, thank you.

>> CHAIR PROFFITT: Very good.

Commissioner Cain, you have a look on your face.

>> CRISTI CAIN: Would it be acceptable to make a motion.
I would like to make a motion to move forward with Delta Dental of Kansas.

>> CHAIR PROFFITT: Okay, we have a motion.
Is there a second.
Second, Commissioner Schmidt.
Any discussion on the motion?
Hearing none, we'll do roll call vote.

>> VICKI SCHMIDT: Aye, but at the proper time I'd like to explain my vote.

>> CHAIR PROFFITT: Very good.
Commissioner Dechant.

>> STEVE DECHANT: Aye.

>> CHAIR PROFFITT: Commissioner Hensley.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: Aye approaches

>> CHAIR PROFFITT: Commissioner Landwehr?
If you're voting, you're on mute.

>> BRENDA LANDWEHR: Aye.

>> CHAIR PROFFITT: Yes, ma'am.

>> BRENDA LANDWEHR: Aye.

>> CHAIR PROFFITT: Very good, thank you.
Commissioner Schmidt, would you like to explain your vote?

>> VICKI SCHMIDT: Thank you, Mr. Chairman, I would.
I'm voting aye on this, voting yes based on information we currently have available.
I do want to be recorded I still believe the process could be improved.
We don't really have a lot of input.
We don't have any input once the bids are received and prior to making a decision other than what we are provided here, and would continue to hope that we'll have more information as we continue to bid as we continue to award, thank you.

>> CHAIR PROFFITT: Noted, we will make sure your comments are appropriately and accurately reflected in the minutes.
The packets do go out about a week in advance, if there are questions with any of the materials, team is more than happy to provide follow up information and more information if we have specific questions that be handled through this process to make it more transparent and a little bit better.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Action item 3, prescription eyewear insurance contract.
This is going to be another RFP review.
Going to be in tab 3 in your notebooks.
Director Flory, I'll let you take this away.

>> JENNIFER FLORY: Next slide, Pete.
The voluntary eyewear coverage is a fully insured product that provides coverage for members, eye glasses, lenses and contact lenses.
The benefits do include coverage for a routine eye exam for members that are not enrolled in our medical benefit or if you're a direct bill member with Medicare and Medicare doesn't always cover routine eye exam, it would be eligible under this program.
We are distinguishing this because if a member has an eye disease or an injury, those services are covered under the medical plan, rather than this benefit.
This benefit is really about hardware.
It's about eye glasses, lenses and contact lenses.
So on the next slide, the current vendor, we have for this benefit is Avesis.
Right now the active employee enrollment we have 32,388.
Of those 9,077 are enrolled in basic, 23,311 are enrolled in the enhanced plan.
We also have a number of direct bill members.
Direct bill members, we have 5,621.

1,000 of those a little over have the basic plan and 4,619 are enrolled in the enhanced plan. This is a fully insured plan, and the employee pays the full cost of the coverage.
We'll go over the premiums on a future slide.
The vendor will take effect with this new benefit contract for three years on January 1.
So on the next slide, we just have for your information, some additional information about the enrollment in the eyewear benefit.
It is currently at 32,388.
You can see the coverage, the active in the yellow.
With the basic, the kind of bittersweet orange is the active enhanced plan.
Our direct bill members are shown in the blue shades.
Kind of a light blue and kind of a gray blue at the bottom.
So on the next slide, we did put this out for bid, and we did receive two bidders.
Avesis is our current bidder, Surency previously had provided this benefit.
Both were invited in for a discussion about their bids and we did request their best and finals following those meetings.
In our review of the bids on the next slide, we looked at their experience with providing a voluntary prescription eyewear benefit.
Provider networks, premium costs, their ability to provide customer service, and their reporting capabilities. So on the next slide, some of the services that are included are access to a network, they this is fully insured so they are fully responsible for all of the claims processing and payments.
They're responsible for reporting, they do have to have a member portal, as well as provide portal for us as well at the benefit office.
They do member communications, id cards and required provide an insurance booklet to the membership.
Again, on the next slide, you're going to see the famous kdot map.
Color regions are what we are going through here.
Just to break the state up.
On the next slide, we have a network comparison.
Again, you will see the areas listed on the far left.
We show you the number of chains and independents included in each one of those networks, both of these vendors have networks that have capacity for our product.
On the next slide, we have the premiums, again this is a fully insured contract.
You will see for each of the coverage tiers employee only, employee and spouse, employee and children and family.
We show you the number that have selected each one of those, whether active or direct bill.
In the next column, we show you the current rates we have with Avesis, in the dark orange, we'll show you the bid from Avesis, this is their best and final bid.
And then in the gold, you see the Surency bid.
On the enhanced plan, you'll notice there's an extra column out there.
That shows Surency alternative plans.
They did bid an alternative benefit option for the enhanced program that the commission may consider if they would prefer that to what we currently are offering.
We will go in a little more detail on that.
So on the next slide, we have the alternative enhanced plan option for progressive lenses.

So this is the alternative benefit for the enhanced program.
You can see for each one of the progressive types of coverage tiers, what the average retail cost is and those retail costs come from imed.
IMED is Surency's partner in providing this benefit.
In the middle column, what the current benefit is, $165 allowance, plus a twenty five dollars material fee.
You can see how that works out. On the far right, you'll see how that benefit would have flowed if we had the current Surency proposed progressive lens benefit.
The other under the enhanced plan remain as the same.
This is an enhancement that the Commission can consider.
As you noticed on the prior page, the difference in rates between the current Surency plan and alternative plan are very, very small.
It's within a few cents here or there for these different options.
So that's another option the commission can consider.
We did ask each one of the vendors on the next slide, we asked each one of them to provide us information about any additional benefits they provided.
This was their   there's an opportunity to tell us about their plan and these are their words.
So with Avesis, they do have an online eyewear shopping tool and offer some additional discounts, refractive Lasix surgery and members have a full year to use their contact lens allowance, which was a little different than some of the contracts we have had other are over the years where a member had to buy all their contact lenses at one time.
Avesis does not require that. Then on the next slide, again, we did the same thing for Surency, asked them to provide us additional details about additional benefits a member might get.
They have the ability to, again, use that contact lens benefit and the frame allowance in the same year.
That's a pretty interesting benefit because typically for a contact lens wearer, if they get contact lenses, then they don't get any benefit towards the cost of a pair of eye glasses, and with Surency, they do get to still use the frame allowance, so that's a little extra benefit.

they do have some enhanced lens options, discounts, they offer Lasix, and they do have access to both glasses.com and contactslensdirect.com with the Surency program.
With that, we are open to questions.

>> CHAIR PROFFITT: Thank you, I do have a few questions myself.
On page 31, the services included specifically the member portal, I'll give you a moment to get there on the top right.
Meant to ask this on the last bid, I neglected to.
The member portal is specific to the vendor. They each have their own member portal.
However, they to provide   we have the ability to link it on our map so the members can go to our map and hyper link out.

>> JENNIFER FLORY: That is a differentiator, a good point to bring up.
So we have, under the membership administrative portal, which we call MAP, you can do single sign on, a link on there to single sign on into our vendor's portals. With Delta dental, we currently do that, and previously when we had Surency, we were able to do that.

Avesis at this time does not have that capability, and that is something that we did ask them to provide us with a performance guarantee that if we went with them, that they would be able to get that single sign on from the membership administrative portal in place.

>> CHAIR PROFFITT: You said Surency does have that capability that did and Avesis does not.
They have a performance guarantee should we move forward with them.

>> JENNIFER FLORY: Yes.

>> CHAIR PROFFITT: On page 34 of the monthly premium costs, the first two columns with the stars in them, orange and goldenrod, are those an apples to apples in terms of what is included, what their cost is based o off of.

>> JENNIFER FLORY: The bidding on the contracts as they exist today.
Then the bottom one is the alternative.

>> CHAIR PROFFITT: The first two are apples to apples, RFP as posted. The alternative plan is Surency costing and all vendors who chose to submit a response to the RFP had an opportunity to provide an alternative plan, is a that correct.

>> JENNIFER FLORY: Yes.

>> CHAIR PROFFITT: Surency you choose to offer that as an option, and Avesis did not, correct.

>> JENNIFER FLORY: Yes.

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

>> VICKI SCHMIDT: Okay, Mr. Chairman, I know when we went to Avesis, they ended up they had a guarantee last time of certain amount of providers in network and before the contract actually even before January 1 of the effective date of the contract, and they were not able to meet their proposals, and so I know we the contract did have performance penalties in it, I guess is what you would say.
So it guarantees the penalties.
So did they propose that same same thought this time is there a penalty for lack of network adequacy for either one of these bidders.

>> CHAIR PROFFITT: Director Flory, what about the performance guarantees.

>> JENNIFER FLORY: In the performance guarantees since both of these currently have a network that's adequate.
We do have performance guarantees that they maintain that network and provide annual reporting to show and if any of those areas, the network decreases, they are required to notify us, as well as they can

be subject to performance guarantees, penalty because they dropped their network in a certain territory within the state.

>> CHAIR PROFFITT: Is there a time certain by which they would need to cure that, to get better and get back to their adequate network?

>> JENNIFER FLORY: Don't believe it currently has a time guarantee that says they have to enhance it by a certain date, but if it continues to be low below their required amount, they would continue to be penalized each quarter.

>> CHAIR PROFFITT: Very good.
Commissioner Schmidt.
We got Commissioner Schmidt still.
Commissioner Landwehr.

>> BRENDA LANDWEHR: I apologize.
Kind of along those lines then, is the guarantee by region then?
According to your kdot map.

>> JENNIFER FLORY: Yes.

>> BRENDA LANDWEHR: And so where are they deficient in?

>> JENNIFER FLORY: I don't believe they are currently deficient.
It is that if their network were to decrease and become deficient, then the penalties would start to apply.

>> BRENDA LANDWEHR: How much is that decrease?

>> JENNIFER FLORY: Do you remember, Paul?
It's 5 percent.

>> BRENDA LANDWEHR: Thank you.

>> CHAIR PROFFITT: Commissioner Cain.

>> CRISTI CAIN: I had a couple of questions, one Surency, you mentioned, Directory Flory, they could use the contact lens benefit and the frame allowance in the same plan year, and that's not mentioned for Avesis, does that mean they don't offer that?

>> JENNIFER FLORY: They do not offer that.

>> CRISTI CAIN: I know we had Surency in the past and was just curious if you noticed a difference in customer service or the level of complaints or issues that you had with either one?

>> JENNIFER FLORY: With Surency we had very few members contact us with issues with regard to coverage.
With   as the commission may recall, when Avesis came on board, there were a number of inquiries, concerns expressed about the network and so we did have more member contact initially.
I think as the contract has gone along, that has subsided substantially, and I think the numbers show that employees are able to use the benefit because we have seen that the number of members taking the benefit from the first year to today has increased.

>> CRISTI CAIN: Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: I want to follow up on that.
On the previous bid for the dental contract.
I know you had a box for customer service for members and that's not on this one.
But I was going to voice that I know that I, as a member, receive several complaints from employees on Avesis, especially when we first started, but not sure that   I mean, I still have complaints about the network.
And I wanted to say that I think that the Surency alternative plan is an incredible plan, especially for any employee or family member that's over the age of like 40 or so, with the progressive lenses.
I think that   I am really excited that they chose to bid like that because the member   the proposed member cost is, you know, on a premium tier 3 is $115 in savings over their   over what they bid in the apples to apples thing.
So when you're ready, I would love to make a motion.

>> CHAIR PROFFITT: Any other comments or questions.
Commissioner Dechant.

>> STEVE DECHANT: [muted]

>> BRENDA LANDWEHR: I can't hear you.

>> STEVE DECHANT: Thank you, Commissioner.
What I was asking is whether there was any computation on savings that could occur, much like we saw on the dental where there's a good deal more expense with one provider than there were with the others?

>> JENNIFER FLORY: There was not.
With the current plan, I'm not sure we have all the information.
The progressive type, whether standard or tier 1, tier 2 or 3 or 4, that's really kind of a Surency, imed tiering system, so I don't think that we really have the ability to monetize that other than what's shown there on slide 35 in the center where it shows you for an individual based on the type of progressive they selected, how much that would cost them.

As far as knowing today with Avesis how much of our employees would have fallen within those tiers set out by imed, I don't think we have the ability to do that.

>> STEVE DECHANT: Should we choose Surency, I would be interested in if there's a way to, and after the fact.

>> JENNIFER FLORY: We can follow up.

>> STEVE DECHANT: Know what kind of impact that may have had.
Should that be where our choice.

>> CHAIR PROFFITT: I think one thing we can commit to speaking, whatever direction we go, or always more than happy to provide any reporting or financials, as long as we have enough lead time to get the data together, we can handle it in house or have Segal help us with that.
Please bring a level of specificity with any questions, we can pull anything we can.
Any other comments before we move to motions?
Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you, Mr. Chairman.
I move that we award Surency the three year plan three year contract using the Surency alternative plan.

>> CHAIR PROFFITT: You've heard the motion.
Is there a second.
Second by Commissioner Dechant.
Roll call vote.

>> VICKI SCHMIDT: Aye.

>> STEVE DECHANT: Aye.

>> ANTHONY HENSLEY: Aye.

>> CRISTI CAIN: Aye.

>> CHAIR PROFFITT: Commissioner McGinn, you're not on yet, are you?
Commissioner Landwehr.

>> BRENDA LANDWEHR: Aye.

>> CHAIR PROFFITT: Motion carries.

>> CHAIR PROFFITT: all right.

Moving on to action item 4, actually I'll make a note that to the extent possible, at the earliest possible hcc meeting in plan year 25, we'll start some reporting metrics as to what tiers we are seeing utilization for the prescription eyewear coverage.
We'll move on to agenda item 4 the Employee Advisory Committee.
Discussion, Commissioners, again, you had information sent to you last week, there's quite a bit of information in here, hopefully had a chance to review and at least get a pre read, we'll have the eac come up and request action on membership to approve that for this year.
And also some bylaw changes.
We have Adam noble here.
If you can introduce yourself.
The floor is yours.

>> ADAM NOBLE: I am employed currently with the Kansas judicial branch.

>> CHAIR PROFFITT: You make sure you're closer to the mic.

>> ADAM NOBLE: Sure, I'm Adam Noble: I'm the current EAC president with the Kansas judicial branch.
Office of Judicial administration, I have two action items to cover as you mentioned within the EAC.
First cover the bylaws, our subcommittee has recommended two amendments to the current EAC bylaws.
An amendment to article 3, membership section 1a, direct bill members, we are shifting from 3 members to two.
You can refer to memo No. 2 pertaining to bylaws.
This will shift a number of retirees from to two three members on the economies.
The second portion within the bylaws, an amendment to article 3, membership section 1c.
Extending the term of the appointment from a three year term to a four year term.
This will apply to all new members of the EAC appointed after January 21, 2024.
I will then segue into the membership committee.

>> CHAIR PROFFITT: Let's take these one at a time.
So Commissioners, that was page 41 and 42 in your books.
Talking about the membership changes, again, a change to the number of direct bill and change to the number of the years on the terms. Any questions or comments or discussion on that.
Commissioner Schmidt?

>> VICKI SCHMIDT: What's the rationale for going from three to four years?

>> ADAM NOBLE: I think we were trying to give the ability for our volunteers for this committee to serve longer.
There is a three year term limit.
It is harder to get more applicants for the committee to fill.
It was our efforts to try and it's been a loss of applicants, I believe.

>> VICKI SCHMIDT: You would be going from nine year total term to 12 year total term.

>> ADAM NOBLE: Correct.

>> VICKI SCHMIDT: Then I was wondering, I know that on page 44, I assume these are your current current once?
Or what is page.

>> ADAM NOBLE: There we are.
You're looking at.

>> VICKI SCHMIDT: Current bylaws.

>> ADAM NOBLE: I believe so.

>> VICKI SCHMIDT: My question is, on the   on page 44 on the conflict of interest, to avoid conflict of interest between members of the commission and the committee active employees who directly report to or supervise members of the commission shall not be members of the committee, and I understands that conflict of interest and I support that conflict of interest, but there isn't   there isn't a thought, if you will for anybody that does work for an elected official on that, and I know that I have had employees apply, and they're not even responded to.
I know they can't be a direct report to me, I have many employees first only have seven direct reports out of 125. "I know that we have had employees that aren't direct reports to me and don't even get a thank you for submitting your application.

>> ADAM NOBLE I WASN'T AWARE OF THAT. The way I feel, if you have the passion to do that and are interested.
I don't know what the change to the bylaws, I can take that to our subcommittee and look at addressing that.
I would have to see how who I have to get involved.

>> VICKI SCHMIDT: I would like to at least suggest that.
The last thing I have is that   and Mr. Chairman, this is a question for you.
I didn't see a change in this, but do we have a Division of Health care finance anymore?

>> CHAIR PROFFITT: Within kdhe?
We do.

>> VICKI SCHMIDT: Their name is   on page 43, the very first paragraph talks about dhcf and so does page 44 under selection of members.
And I just   because I think it was just missed when the transfer took place.

>> CHAIR PROFFITT: I would agree.
We will   if the commission is okay with it, a decent cleanup, when the transfer was made, we can call it the Division of SEHP.
Commissioner Dechant.

>> STEVE DECHANT: Explain to us the rationale for increasing the number of retiree members of the commission?

>> ADAM NOBLE: We have had issues kind it's harder for retirees to fill in because, unfortunately, if you're not serving as an active member, you don't get compensated really to travel and depending on your location if we are trying to have it here in topek about. Yes were doing our best to try to reflect what the bylaws say about keeping it spread out and equal representation, but unfortunately, I think it's just been more difficult to fill that third slot.
So it was not an intent to slight that portion of it, but it's just trying to keep the amount of representation available.

>> STEVE DECHANT: What sort of percentage of vacancy have you had in those three positions over the last couple of years?

>> ADAM NOBLE: This is only my second year, first term, I'm kind of on a learning curve.

>> STEVE DECHANT: Were you absent the meetings they elected the chair?
That's meant to be funny.
No, I'm sorry.
What can you say to that question?

>> ADAM NOBLE: I know I'm on the membership subcommittee, we are trying to look more into that.
There have been a lot of changes in here.
Trying to get a good base line within this committee and good practices moving forward, so I don't want to misrepresent or misinform.
I'm not entirely 100% certain.
I will definitely try to get down to that and give you a better answer when I get the chance to find it.

>> STEVE DECHANT: I can identify with the commitment by a retired person since there's not the benefit of probably official leave time to travel as well as being paid for that time.
I have a little bit of a concern because it does retirees make up a 6th or 7th of the pool of people that am are covered by the state health insurance plan and three members happens to be about a 7th of 21.
I have more of a concern, though, that I notice in addition to changing the number, you also eliminate the requirement that one of those two retirees be a Medicare eligible retiree.
Am I did I read anything or something.

>> ADAM NOBLE: I may have missed that portion in here.

>> STEVE DECHANT: On the memo, the section that talks about new language under article 3, section 1a, changes the number to 2, that will be who shall be covered by state health care through direct big due to their prior employment.
That's it.
Whereas currently it says of which two of the three should be retired employees eligible for Medicare.

I can understand the difficulty, but I think there's a clear enough distinction, I've served on this body both as a Non Medicare eligible retiree and now as a Medicare eligible retiree and there are different concerns that occur during those stages, and not that it requires a person who is Medicare eligible, but I think it it at least brings that perspective to be voiced because there's a personal interest possibly, and I would like for you to consider or for this body to consider retaining that one of those two members be a Medicare eligible person.
That probably doesn't help your concerns in terms of recruitment, but I think maybe well, it's what I it's a proposal I would make rather than making the change to only direct bill, but rather keep one of those direct bill members as Medicare eligible.

>> ADAM NOBLE: Point of.

>> CHAIR PROFFITT: Point of clarification from staff and legal counsel.
The action item before us would be to either approve or not approve the changes to the Employee Advisory Committee bylaws, that's a correct statement.
Getting head nods. Should we choose, we could send this back to the EAC and ask them to review with the potential to add a erequirement for one of two the two Medicare.
Just want to make sure we are clear on the action item.
It would be deemed not approved at this meeting if we choose to do that.
Determine if they want to do it and bring it back at the next meeting.
Be a lot of head nods.
Want to make sure we are clear what the steps are.

>> STEVE DECHANT: We would have to not approve that particular change today.

>> CHAIR PROFFITT: Add the caveat you're recommending they make that change you are wanting to see.
Make it a clear message.
Any other Adam.

>> ADAM NOBLE: I know previously you said two.
At least one.
I mean, I want to respect whichever choice it is you have.

>> STEVE DECHANT: With the new language, changing the number of retiree members from three to two.
I would like to continue seeing that I guess currently it requires two of them to be Medicare eligible, I would like for it to require one of the two at least one of the two tore Medicare eligible.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I don't want to muddy the water.
Do you want them to be Medicare eligible or be Medicare Supplement holder?
I mean, that's different.

People can be Medicare eligible and not be on a supplemental plan?

>> STEVE DECHANT: I'm comfortable with Medicare eligible.

>> CHAIR PROFFITT: What it currently states.

>> STEVE DECHANT: It simply says should be retired employees eligible for Medicare under the current language.
I'm comfortable with that language, but making it only one of the two shall be.
Eligible for Medicare.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: That means you could be a retiree of the state, not be on any of the plans that we have to offer, but you could be Medicare eligible because that's what Medicare eligible is.

>> JENNIFER FLORY: Can I clarify.

>> STEVE DECHANT: Calls for the person to be a direct bill member.

>> CHAIR PROFFITT: I think Directory Flory.

>> JENNIFER FLORY: They must be enrolled as a direct bill member to be eligible to participate on the EAC and must have the medical coverage.
That would be either a medicare supplement, Medicare Advantage or being an early retiree covered under the active plan.

>> VICKI SCHMIDT: Could you not be a direct bill and not have dental?

>> CHAIR PROFFITT: Yes, you have to have direct bill member with medical coverage to be considered for serving.
Is what I'm hearing.
So dental would not qualify.

>> VICKI SCHMIDT: Covered by a state health plan.
Isn't the dental plan part of our health plan offering?
I don't want to mince words, I want to make sure we get it right.
I consider the dental plan or the vision plan part of our health plan.

>> CHAIR PROFFITT: We need one moment.
not to get ahead of any motions or votes.
Will if we move down the path of sending this back, we can ensure there is language in there that states needs to be a medical plan to be covered to ensure that it is somebody, if it is Medicare eligible that is direct bill, included in the medical plans.

Commissioner Schmidt?

>> VICKI SCHMIDT: Yeah, I don't know what the exact words are, all I'm saying, I want to make sure we are doing what you   that we select what Commissioner Dechant   the words Mr. Dechant would want to make sure that it happens.
I just   if you put the Medicare Supplement in there, wouldn't   Medicare   anyway, I'll let the lawyers or whatever, the professionals figure that out, but thank you.
I think just so   I think you know what we're trying to say, just so we get the right language.

>> CHAIR PROFFITT: Let's go ahead and formalize this with a motion and work through the details. Do you have a motion, Commissioner?

>> STEVE DECHANT: I move that we approve the proposed amendment from the eac related to length of terms, which I believe, if I've got this right, article 3, section 1c.
You want two separate motions or one.

>> CHAIR PROFFITT: Two separate motions.

>> STEVE DECHANT: I'll stop with that.

>> CHAIR PROFFITT: Is there a second.
Second Commissioner Hensley, discussion on the first motion, which is to approve the change in the term.
Hearing none, all in favor, please say "aye."

[chorus of ayes]
any opposed?
Motion carries, do you have another motion, Commissioner?

>> STEVE DECHANT: I do.
I move that we send back to the EAC the item they recommend in regards to numbers of members, asking that they review and consider that in decreasing the number of retiree members down to two, that they retain that one of those members, using the correct language, be a direct bill member covered by medical and eligible for Medicare.

>> CHAIR PROFFITT: Okay.
You've heard the motion.
Is there a second, second Commissioner Hensley, discussion on the motion?
And if it's okay with the maker of the motion, we will leave flexibility for legal staff and staff to clean this up in a manner consistent with the bylaws.

>> STEVE DECHANT: Certainly.

>> CHAIR PROFFITT: Very good.

Okay, all those in favor, say "aye."

[chorus of ayes]
any opposed?
Motion carries.
Mr. Noble, Commissioner Hensley.

>> ANTHONY HENSLEY: Yes.
Page 40, is that the current membership?
Page 40.

>> ADAM NOBLE: I have not seen this list myself.

>> JENNIFER FLORY: Yes, this is the list of the current members.

>> ANTHONY HENSLEY: Just out of curiosity, the person that has been appointed representing the Kansas Department of Aging and disability works in Cass county, and lives in Cass county.
I didn't even know Cass was a county in Kansas.
I think it's a county in Missouri.

>> CHAIR PROFFITT: There is a Cass county, Missouri, I'm not familiar with all 105.
I'm assuming he is.

>> ANTHONY HENSLEY: Do we have an office of the in Cass county?
I'm curious about that.

>> ADAM NOBLE: I'm honestly not certain.
I'll have to get back to you on that.
I'm wondering if that was where she resides and then she works within the state.

>> ANTHONY HENSLEY: Just looking at the column.
County of work.

>> CHAIR PROFFITT: Both county of work and residence.
It warrants further review and consideration, we'll make sure it's updated appropriately for the next meeting.
Thank you for the catch, Commissioner.

>> ANTHONY HENSLEY: The guy at the bottom of the list, he lives in California?
Scroll down.
Says San Mateo, California.

>> ADAM NOBLE: Retiree, living in California, yeah.
But he's a retiree.

>> ANTHONY HENSLEY: He worked for us then when he was working.

>> ADAM NOBLE: A retiree of the state, resides in California.
He remotely joins us.

>> ANTHONY HENSLEY: Thank you.

>> CHAIR PROFFITT: All righty.
Mr. Noble?

>> ADAM NOBLE: Second item was pertaining to membership.
The membership subcommittee has vetted for approval the following new members.
Joseph coburn for the University of Kansas.
Lori Scott drilling, west Pittsburgh state university.
Melissa marish with the Department of Children and family.
Sarah miles with the Department of Education, and within the regents.
Cassandra Steele within judicial administration and Michelle huntsman with Department of Administration.

in addition, the EAC would appoint the following   reappoint the following nominees to serve on the eac.
Drew Campbell, Department of Administration, Oren Webb with the Kansas board of healing arts and Mike Mercer with the Emporia state university.
Terms of state January 1 Huff 24.

>> CHAIR PROFFITT: Commissioners, any questions on the membership?
Commissioner Schmidt?

>> VICKI SCHMIDT: So moved.

>> CHAIR PROFFITT: We have a motion.
Is there a second.
Second, Commissioner Hensley.
Any discussion on the motion?
Hearing none, all those in favor, say "aye."

[chorus of ayes]
any opposed?
Sorry, Commissioner.
Any opposed?
Motion carries, members are approved.
Thank you very much.

>> ADAM NOBLE: Thank you for your time.

>> CHAIR PROFFITT: See you at the June meeting with the updates to the bylaws.

thank you.

all right, moving on, we are complete with the action items component of the meeting, move to on reports, in tab 5, Segal will walk us through the financial report.
As they get up here, we are going to go a little bit out of order over the next five items, on the financial report, we will get most of the way through tab 5, and I would ask you if you could to stop prior to page 64, which is where we start seeing what would be the section for plan design for 2025.
We can get through the financial report and put a pin in this component of it and moved into the other discussion item which would feed back into this and we can bring you back up here for that.
Without objection, that's how we'll move forward, commission.

please take us away.

>> Ken with Segal.
In February meeting, Patrick Klein went through a lot of the year end numbers and did some projections for 2024, 25, forward.
And in a nutshell.
This projection really hasn't changed much.
The enrollment was slightly higher, barely higher, which raised the expense a little bit.
Raised the revenue a little bit.
All the ending reserve balances are the same projected for this year, going forward, still at the 6.9 percent rate.
That being said, what we did do last time, didn't roll out the monthly numbers.
Added through February, that's included and going forward we had reconciled to it.
As you go through year to date the same number because we rolled out the monthly numbers.
On this page the only variance because there was a delayed payment for vision administrative expenses, so that will be paid in March, year to date, a little bit of a gain because that wasn't paid yet, but comes out in our March number and be out at the end of the year.

all right.
Next page, Pete.
How do I do it?
Okay.

this is the enrollment data.
You can see we have variance again, slightly higher, I think we had 37848 actives and a little bit higher than that now and retirees are about the same.
Interesting to note hasn't changed about 50 percent of the people in the plan, Plan A and the other 50 percent approximately are in the c&n combined, health savings account plans.

did I skip one?
No.

on the next page, this is the projected revenue and expenses over the next four or five years.
The number I said are a little bit higher than last time only because the enrollment and revenue has gone on.
The year end balance that the 62.7 that was 62.8 before, so it's pretty much in the same ballpark so the January and February data didn't change the numbers from what we projected in February.

The reserve levels, I mentioned before we are still at the same 6.9 percent level.
And that hits the employer groups on dates and hits the employees on a 1 1 date.
So it's all the approved changes you have already made and going toward to balance out to the end of the period we are at 6.9.
Same number we had in February.

and then this is, again, the event pack numbers.
If you had higher or lower trends, obviously, it's brands and broadens and broadens and it can cause substantial variance in your cash balance.
No different than pretty much what we have projected.
We can change this maybe to be plus or minus 1 Hewlett Packard to make it a little tighter.
Maybe take note over a period of time it wouldn't be as big of a deviation, would be more of a typical variance we would expect.
Then there's just a bunch of the same assumptions in the back, next assumptions, acronyms and the actual model.
This is where I mentioned now we are rolling it out by month, and March going forward, we'll start showing the variance, you can see how we are comparing to actuals as they come through.
this is part of the model.
this is part of the part of the model.
I believe everybody is aware of where you can change the component pieces.
We have done on the fly modelling before in front of you all.
This is where I'm stopping.

I think in general, nothing surprising, it's consistent with what we projected in February and like I said, some stuff on the plan design we'll talk about.
There's some follow up in the back about I know you wanted benchmarking breakouts, got those in the back as well.

>> CHAIR PROFFITT: I do have a question, you mentioned you could tighten that up to a 1 point corridor.
Do you have historically how closely we have come in.
Could we get a leading into trailing four years what the trend was projected to be versus what it was, plus or minus two, to show how far up we can get, but if we can show a level of confidence coming in so we have some level of understanding, the context what plus or minus would be.

>> KEN: We can do that.
I know in the last presentation, we had a budget to actual variance for the last three years, had that in the report, it was part of the report.

I think over the last three years, it was close to 0, so close to being would imply we are close to the trends.
It does vary year to year, Especially when COVID came through, it kind of moved.

>> CHAIR PROFFITT: I think if we can used it to the graph so we can see what the trends were coming in, plus or minus 2 percent even within the realm of possibility or will something have to go to get off there.
Why on page a 1, fund balance versus target surplus and short fall, looks like we are under current projections falling short of 2025 by 7.9.
14.9 million in 26 and that grows a little bit in 27.
Obviously the target is the target, that's where we want to be, at what point do you start flashing the red light?

>> KEN: That bottom section is the higher level of the target.
That's what we have done before the house bill came through.
The top one doesn't deviate.
Only like 2.6.
We do get the 10 in 2027, which is significant.
207 is a big year because you have an extra claims payment too, it loads up that year a little bit and then you start to get the impact of 6.9 because that's delayed, only getting a half a year, the full year the following year.

>> CHAIR PROFFITT: The top target is your plus or short fall relative to the legislative target.

>> KEN: We talked about taking off the bottom part.
That's something we did a long time ago, had it in there.

>> CHAIR PROFFITT: Been a couple of years since the legislation passed, if you can track that internally, I would be happy if we track state law, track versus legislation so there's no confusion.
Any objections to having them remove that?
Seeing none, okay.
Appreciate what you're trying to accomplish that.
One set of numbers here.
Okay.
Commission, any questions on this component.
Commissioner Schmidt?

>> VICKI SCHMIDT: That's my note on page 51 also.
I appreciate you bringing that up.
Also on the report that you've requested, I would like to know what the what Segal projected that we were supposed to go up to because I believe that every year, since I have been here, they have projected an increase that for the next year, and we have I'll say set that aside and have done either we have decreased some or we've gone zero.
I don't believe we have increased any of the parameters since 2019, maybe.
2019.

So what I'm trying to get at is I think that they always recommend an increase, we don't do that, we have our history would say we have not done that.
We have done that on the employer side.
So I should I should have said that originally, sorry.
We have done on the employer side, but haven't always done the employer side as much as what they have projected us to do to stay to stay above water, and we have continued to at some times even build our balance during that.
So I'd like to know what they projected us to do one or two years out and what we actually did and then look at what happened to the balances because, you know, I look at the 6.9 percent and quite frankly I discount it because why ever year they predicted we should go, sometimes it's been in excess of six point the percent and we haven't done that.
I would like to know how accurate the projections are.

>> CHAIR PROFFITT: Make sure I'm understanding the request.
Look at what the projections for the total increased funding net of employee and employer contributions with the forecast was and where we were going to be and where we landed because we can't just do one without the other.
Having both increase and what the projection would be.
Okay.
I believe there was a $10 million infusion into the reserve balance two years ago.
So at the point that the forecast was made prior to that coming in, we would have to back out the 10 million to show that.
Just to make I understands the intent, want to make sure we are not throwing the model off without taking into account all the variables.

>> VICKI SCHMIDT: I think there was one $10 million infusion, that was the only time since 19 that I recall that.

>> CHAIR PROFFITT: Can tell you that was the only time there was that since 2021.

is that something you guys are able to prepare for the June meeting?

>> KEN: I think that's what we put in the last report in January, it had year to year to year the budget versus what we projected.
So that was in there.
I guess we could do a longer the early one, two years out what we projected with trends.
Trends have run lower than like in that analysis assumed versus actuals.
It runs a percent and a half lower, pharmacy runs a percent and a half lower, that would create gains as you go forward.

>> CHAIR PROFFITT: Think if we can three or four year outlook, go back and do a trend, what we were projecting for the increase to be employee, employer combined, and to the extent there was a variance of a savings or gains rather, if there's a mix analysis or chart that you can show what they were that led to the variance, that would be helpful.

>> BRENDA LANDWEHR: Thank you.
Commissioner Landwehr, got to get used to that.
I like having that spread out, and I think separating out any quarterback fusion that comes from the legislature is important, that money won't always be there.
I think it's important for us to get a clearer picture of why we are running into the deficits. Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: I was wondering on page 54, adjustments from RFPs, talk about a pbm's RFP and saving of 25 million in 2024 and 39.9 million in 2025.
I assume that's due to rebates, pricing and formulary changes, but I want to make sure I understands that.

>> KEN: That's correct.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: All right.
Seeing no further questions, Commissioners, we'll have another shot for questions here in a little bit.
Thank you.
So we are going to put a pin in five.
We are going to come back to that tab in a little bit.
Want to move into the next couple of discussion topics as they will come into play with 5.
If we move into 6, nothing in your books there, it's empty just for plan year 25, I'll reiterate this again at the end of the meeting, somebody please keep me honest.
Our next discussion on June 3 is when we will make plan year 25 decisions as a commission.
So there are going to be some items preluded in here already.
The Segal will walk through when we come back, but if any Commissioner has any item they wish to have for consideration for the June meeting, our request is that you have that information at as specific a level as possible by May 10.
Send them to Directory Flory and myself by May 10.
Anything you are looking at changing so we can used that to the model.
Segal does have the spreadsheet model we walked through in realtime at the June meeting.
If they have that, that will give my staff time to work through that and get something prepared and we can have something ready to go in advance of the June 3 meeting.
That's the time frame we are under and may 10 is a Friday.
So if we move on to tab 7, one of the circled back on this topic, a pans and pandas report we did submit to the legislature on February 29.
Before the final final deadline, thankful because we are in a leap year.
Wanted to make sure that everybody did receive this back in February.
Had time to review it.
Wanted to make sure since this is a report that went to the legislature, there was an opportunity for questions should there be any.

Segal is present and able to walk through this if there are any particular questions.
As a reminder the way this is broken out the first several pages lay out what 2022 house bill 2110 provided for the Pilate, what some of the projections were what the plan year 23 finals were, and then behind that, in exhibit c, it has a 2022 house bill 2110 review, and this is a presentation that was provided to the appropriate committee prior to the pilot passing the legislature.
Just as a reference point.
I'll go ahead and get ahead of any questions now.
There was a question about whether or not this should have been included in plan year 24.
I will say, again, we do the next plan years meeting and design meetings in June of the year, given the coverage started for this program on January 1, we this claims run out and having a June meeting, there would not have been appropriate time to make a decision or determination about there wasn't enough claim history to really be able to speak to anything at the June meeting, we did make the determination to cover it into plan year 24.
$82,000 worth of claims, what we did not want to do is the legislature has next year to make a determination on whether or not to continue this coverage in perpetuity, we did not want to remove the coverage for plan year 24 only to add it back in plan year 25 should July 1, 2025 the legislature choose to take action.
So if there are any concerns on that, please direct those concerns at me, that was the decision and determination.
Apologies if anyone was offended by that.
The intent was to make sure we had continuity and have a full year of runout.
With that, Commissioner Schmidt.

>> VICKI SCHMIDT: Thank you, Mr. Chairman, I I just believe that hcc should have been at least had an opportunity to have the discussion.
I would clearly have voted for it to continue, but I think not for the hcc is responsible for plan benefit and plan benefit designs.
I would just ask that next time, if there is a next time, we are included in that.
I guess I may I as long as we are on the pans and pandas issue.

>> CHAIR PROFFITT: Please continue.

>> VICKI SCHMIDT: I know on page 65, when on the Segal information, it says terminating pans and pandas coverage and terminating Amino acid formulary coverage, I don't understand that language, why wouldn't it saw inclusion of instead of terminating because when we get to plan design, I fully I'll make this request by May 10, I'll make the request, but I want to see those included.
I don't want to discontinue the coverage for any of these individuals, I'm just asking that the hcc have a part of that.

>> CHAIR PROFFITT: Fully understand.
We'll get to that discussion when we circle back to that component of the meeting.
There is a very valid reason in there. Why we'll get to that when we get there.

>> VICKI SCHMIDT: May I ask questions about the report itself.

So on page 75, of the report, that was submitted, I am really struggling with general surgery claims, I actually went down a deep dark hole, I guess over the weekend and looked at pans and pandas treatment and surgery is never listed as a treatment for pans and pandas coverage.
Yet we paid for we had 15 unique members that had general surgery.
So was general surgery really with pans and pandas or was it a secondary surgery relating to pans and pandas, because general insurgence is not general surgery is .

>> GINA SANDER: This is Gina Sander with Segal.
I will have to clarify that with Blue Cross Blue Shield, this is the information they provided us through your specific experience with the codes that they use for this coverage.

>> VICKI SCHMIDT: I know plasma phoreesis one of the treatment modalities. That isn't surgery either.
So I mean, that may even make our expenses go down our experiences related to pans and pandas go down decrease further.
And then I guess I'm struggling a little bit with the estimations that you provided on page 80.
When this as I understands, this report was before the legislative body, and you estimated the minimal impact and then the highest prevalence, you estimated like 211,000 and we were like at 70,000 the lowest at 704,000.
That's a long way off of what we actually encountered.
I was wondering if you might want to respond to that.

>> GINA SANDER: All of this is national research we did.
National treatment costs and national prevalence during this time, back in 2021 and some of the data was from 2020, it was just a bunch of research that we had found, and when we made the estimate.
You'll notice these are based on per treatment costs and in the report, it talk about the delay in actual treatment and prognosis or diagnosis of these symptoms.
Your coverage of this had only been in place for one year, and I don't see any high level treatments in here.
All of the experience you have in 2023 was primarily diagnostic and maintenance type.

>> VICKI SCHMIDT: I hate sorry to interrupt, but that isn't true.
This was the report you gave to the legislature in 2021.

>> GINA SANDER: It is.

>> VICKI SCHMIDT: This was projections.

>> GINA SANDER: These projections were based on the cost of treatments and the prevalence counts.
And so we took the prevalence, .5 and .15 and applied it to the age group of 3 to 14, in Kansas's population, those are the members that would be most likely to be affected by this and applied the per treatment cost that we had found in the information.
But, you know, clearly not all of those may receive treatment.
This is an estimate estimated cost of the treatment per individual.

>> VICKI SCHMIDT: It's SEHP population.

>> GINA SANDER: Correct.

>> CHAIR PROFFITT: When you say the high cost has not hit Kansas yet, you may for plan year 23, which is what could have led to the discrepancy.

>> GINA SANDER: Which is why it's so much lower.

>> CHAIR PROFFITT: The 200,000 from a couple of years ago would be a fully mature plan and not the first year of implementation.

>> GINA SANDER: I think that would be fair to say because that was based on treatment cost.

>> VICKI SCHMIDT: Okay, we wouldn't have that yet.
We are only in 2024 plan year, only three months   three months in.
Maybe at the mid point we cooled a true number.

>> GINA SANDER: Updated figure, yes.

>> CHAIR PROFFITT: By June we will have the most current information possible.
We won't have a full five months of data, whatever that we have available we should have within the packet before the June meeting.

>> VICKI SCHMIDT: Okay.
Lastly, Mr. Chairman, I was wondering, I would like my letter to at least be included in some form in the packet in the minutes if you don't want to, you can tell me.

>> CHAIR PROFFITT: I would prefer not to, quite candidly.
If there is still a dissent position after reviewing this information, I would be happy to have that conversation, given that was submitted in the official record to the speaker of the house, I would also take objection to some of the comments that were put in there, some of the copy and paste from my comments that left some of the other comments out of there.
I would want to discuss this with you before putting it in there.

>> VICKI SCHMIDT: Welcome that conversation.
Thank you.
Commissioner Landwehr.

>> BRENDA LANDWEHR: I guess this kind of raises the question of the fact that we used the state employee plan to test out any potential insurance mandates the legislature might consider what I'm hearing with this experience is that you are telling us a one year experience is not enough.
The legislation should have been for two years to give us a full impact study.
Would that be accurate?

>> CHAIR PROFFITT: I believe my comments were at the June 2023 meeting when we discussed plan year 24, we would not have nearly enough claims experience to make an informed decision, whether or not to cancel skis some, suspend the coverage at the end of the 2023 year.
It was my determination as secretary of administration lead of the SEHP team we should leave that in for another year so we are not going back and forth, back and forth.
I think the legislature in the report we are submitting here does have a full year fully run out claims history and the experience so the legislature could take that information and make a determination.
The legislation did say that the legislature would not take that up until the year following the report.
That would be the next legislative situation, clearly we'll have more claims experience given the fact we are covering in 2024 as well.
A more informed decision for the legislature at that point.

>> BRENDA LANDWEHR: If they don't take it up until 25, it would be your intention you have the intention to authorize through 24 and 25.

>> CHAIR PROFFITT: Now that we have a full year, the hcc is clearly in a position to have the data to determine whether we continue this in 25, which is what we'll get to in the next section.

>> BRENDA LANDWEHR: I voice my opinion here a little bit, I just felt like the statute was clear, the program was supposed end to at the end of the December and there could have been a meeting called.
For to us make a decision to continue it, and I just thought it was wrong for one individual to make that decision, thank you Mr. Chairman.

>> CHAIR PROFFITT: Very good, thank you.
Commissioner Schmidt?

>> VICKI SCHMIDT: Mr. Chairman, I would agree with representative Landwehr, I think that pilot program statute needs updating because I do believe it puts the hcc, the SEHP and the legislature in kind of an awkward position because you don't have the claims data in by the time you're trying to decide for the next the next year.
Now I understands there could be times when those are I can think of scenarios where those could be astronomical amount of and we could go back and visit with the legislature and visit with how that played out, but I do believe, and I believe that as a legislator, when we did the autism program through the SEHP, that the timing is just not awkward, it doesn't flow, it's just awkward and doesn't flow and so I think that the legislature should take a look at those statutes representative, Commissioner, Commissioner representative, whatever your title is right now, Brenda Landwehr, I think you ought to look at those and I think maybe with the hcc and staff, we could help them make a better one that is more friendly to rolling out.

>> CHAIR PROFFITT: Appreciate the input.
Don't think there's my disagreement around the table the timing is not conducive to making informed decisions with the level of information you would have at the time you have it.

Why don't we take this action and forward the August, September whatever the two meetings from now, we can have a discussion on if the hcc wants to make a proposal to the legislature to make any updates on that.
Certainly worth having the discussion to make sure that we are giving our legislative partners all the information they need to make informed decisions, I think they would appreciate that.
Any other comments, questions on the pans and pandas report?

Commissioner Dechant.

>> STEVE DECHANT: I don't think theirs any other good decision to be made to continue it.
I think we started something and apparently there were whatever hitches, but I think that it was responsible and reasonable and the right thing to do to continue this year.
Have an opportunity to weigh in towards the end of the year, we'll run into the same thing, run into the legislature's not having the data from 23 and 24 to review until after 24 ceases to exist.
Either we choose to drop it and leave those people wherever they're at or choose to again, we'll be discussing this, we'll have the same kind of thing happen even if we as a body have an opportunity to weigh in.
Same kind of decisions to make that were made independently earlier this year or late last.

>> CHAIR PROFFITT: Thank you.
All right.
Seeing nothing else, we'll move on to agenda topic No. 8.
A discussion only talking about residential treatment.
This is in tab 8 on your books, just a couple of slides here.
Three total slides, I believe.
Questions raised at the last meeting in February 16 about residential treatment facilities and there was a determination made in 2020 though make sure the state health plan was compliant with mental health parity and do some digging in who was involved in the decision, what data was in there to drive the decision, how the decision became informed.
There was some questions about what level of benefit might have been taken away from state employees, on page 94 here the yes is as was submitted to state employee health plan and myself about the market study and how the decision was made.
As you can see at the blue comments, CMS did conduct a market study in 2018 and 2022, back to the time frame, that would have been at the start of that, state employee health plan was in kdhe. Towards the end of the that, transitioned over to Department of Administration.
These discussions involved staff from CMS, secretary of administration, state employee health plan legal counsel from kdhe.
Started with kdhe again and I think when the decision determination was finally made, SEHP staff, Segal and the tpa were involved with that as well.
What had happened, CMS reviewed the plan's coverage, which included swing bed coverage and determined this to be residential treatment.
The plan was not required to cover residential treatment for mental health or SUD unless it provides the coverage for medical coverage.

Absent some level of change either including mental health or eliminating the swing bed, the plan would have been deemed to be out of compliant with mental health parity.
The State Employee Health Plan utilization for 2018 and 2019 identified zero claims paid for skilled nursing swing beds in 2018 and 2019.
Discussions with the parties listed above determined that because no claims had been paid by eliminating that, we were not removing a benefit actively being utilized by members and did help us become compliant.
Plan year 2019 was the final year of swing bed coverage and from that point forward in 2020, CMS dud deem SEHP to be compliant with mental health parity.
I want to clarify there was   I don't know if it was a comment or question during the last meeting about eliminating rehab from state employee health benefits.
It's not entirely what happened.
So again this is just swing beds, swing beds meaning a skilled nursing rehab type mostly in a rural setting where there's not a residential rehab facility available.
So if, for example, if a state employee were to need to go to Kansas rehab facility as a provider here in town and receive, be admitted on a inpatient basis, acute facility, they do get coverage, this determination did not change any of that.
So rehab is still covered in that setting.
This determination did not change anything on that level.
There are some rehab facilities that are longer term facilities maybe Craig out of Denver, that today the medical components and all the outpatients, any of the medical components are covered, the residential stays, the room and board is not covered, that was true prior to this decision, that is true today as well.
So stated differently, this determination made back in 2020 had no impact on the coverage for residential inpatient those facilities, did not have any of those unintended consequences.
Wanted to make sure we clarified that.
A few other questions on page 95, how was the decision to update the benefit plan description communicated. Any time federal law or state law changes, or changes made but hcc, the benefit description is communicated, with the tpa's, Department of Administration legal who is counsel for the hcc and the SEHP consultant, and we discussed the language in the updates and changes that are going to be necessary.
These documents are provided to members and posted on the SEHP website.
Average opportunity for folks to see the new benefits description.
How often is this reviewed and updated, the benefit description is reviewed annually and required updates are done annually as well and does SEHP work with outside counsel, the answer is kind of, yes, we start with primarily d of a counsel, and we do consult with the tpa's and our consultants counsel as well.
Do bring in outside counsel with d of a having the final determination.
So that is sort of the history as it was, we have been able to go through and I find.
As it relates to inpatient acute care settings, rehab, none of those benefits were taken away as it relates to the residential inpatient being not a covered service, some of those longer term care facilities, that's been a policy for a number of years, which was prior to this determination made back in 2020.
So this was made, again, making sure we were in compliance.
I will say that back then, 2018, 2019, likely in a different market, or landscape as it relates to what I see covered and not covered, given the information that was available at the time and at the time that this

decision was made, appeared to be one well intended and did not have an impact on anybody, certainly for the prior two years, no claims in that arena.
Does not mean that it's still the right decision, means at that point in time, different landscape as it relates to residential treatment.
So that is sort of the become background we were asked to go through and look for.

any questions on this before we move into a little bit deeper discussion on this?

Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you, Mr. Chairman, I want to preface my remarks by saying I do respect you immensely and do respect the decisions you make most of the time and you weren't around when these decisions were made.
But I don't understand that if for example, I don't remember what page it is, but the page that has like the from Segal about the possibilities of orthodontia, those are changes in benefits and you we do that at the hcc when we talk about benefit design and we talk in June, what we are going to hopefully do in June about what we want to add and what do do we want to change anything.
I don't understand how a major decision like this could be made, because to me, this is major, because I believe that the that the state employee health plan is the outlier, 100 percent I believe we are the outlier and not covering room and board for SUD.
And I so I don't understand so it makes me want to know, what other decisions does SEHP make for benefit design that hcc never even hears about.
What how does that work because I firmly believe that h cc should have been consulted at this juncture for this because we have been sued for parity.
We have had not a secret.
I also wanted to know on the SEHP consult with outside counsel, when you say consultants counselor, is that Segal on page 95?
On the last is consultant counsel Segal?

>> CHAIR PROFFITT: Work with the tpa counsel, it's necessary to make sure we are in line, consultant would be Segal in this instance as the actuary.

>> VICKI SCHMIDT: How many times in the past year have we consulted with Blue Cross & Blue Shield and Aetna on benefit changes?
Is that monthly, does that occur once a year?
When does SEHP consult with the tpa on plan design?

>> CHAIR PROFFITT: I don't have the answer off the top of my head, that's not one of the questions submitted in a question format.
I would certainly if we make any plan design changes, that is something we should be looking to them before and understand the implications there.
Absent any plan designs and changes in the foreseeable months, I have not had any meetings about that.
There has not been a need.

>> VICKI SCHMIDT: And then maybe not directly related to this, but somewhat related to plan design, it has come to my attention that there are different   I mean, as I would expect there would be, there are different coverages, but Blue Cross Blue Shield of Kansas continue cover the exact same thing as Aetna and vice versa.
They are different plans, have different plan documents, file different plan documents.
I would be interested, has   has anybody ever looked at that and   because I think our employees might choose a different plan if they had the information, but when we looked through the document, the plan document that we send out to all the employees, we don't say, like, this is covered in this plan, but if you have this disease state, you might want to look at this plan because you might want to look at the other carrier, it covers more of that have we ever done a plan side by side comparison of coverages?

>> CHAIR PROFFITT: Look at Directory Flory to walk us through the plan design documents have, high level consistency across the two.
I want to make sure I'm not getting off track here.

>> JENNIFER FLORY: That's correct.
So we have a base benefit document and then to that document there's a schedule, and the base benefit document is discussed with both Aetna and Blue Cross & Blue Shield on an annual basis and it is the same document.
There are some places within that document such as things that are specific to that vendor that they customize in the final document that goes out, such as things like appeal processes, mailing addresses, but the base document is the same for plans a C, j and n, the schedule is separate.
And so that is a separate piece we modify for those particular plans   because c and n are qualified high deductible health plans, there are certain things that were not allowed to do   so, for instance, I believe allergy treatments are available under Plan A, and you don't have to meet the deductible.
They're under the preventive benefit.
Under c and n, we couldn't do that because they are not highlighted within the qualified high deductible eligibility statutes, so there's some slight one or two differences, between a and c, j and n as far as plan coverage.
But they're pretty minor.
Otherwise, the document is the same document, we just modify it to add the specific things that we need to, to be in compliance.

>> VICKI SCHMIDT: I'm not talking about between a, c and n, I'm talking about Plan A only, and unfortunately, I have firsthand experience in the treatment of breast cancer, and Aetna and Blue Cross & Blue Shield are different in what they cover.
I think that is important to know.
I can only tell you about that particular one, but if the plan document says you have to cover breast cancer treatment, I can tell you that it is not specific enough because there are plan differences.

so that's what I'm asking, so I think it ought to be delineated out.
If you have breast cancer, this will not be covered on this plan, but covered on this plan, and those aren't to me, those aren't minor differences, those are big differences.

>> CHAIR PROFFITT: Noted.
Why don't we talk the action item to look at the plan documents for the two carriers and see what the differences might be in coverage and if you have specific examples, show staff what was or was not covered to point us in the right direction.

>> VICKI SCHMIDT: I wish I didn't have that firsthand experience, since I do, I'm going to use it.

>> CHAIR PROFFITT: Happy you got the coverage you did.

>> VICKI SCHMIDT: Well.

we'll talk about that later.

>> CHAIR PROFFITT: Fair enough.

>> VICKI SCHMIDT: On the residential treatment followup, I know this is a discussion item only today or that's what your preference is, I can understand that, but I absolutely think that we are doing a disservice to our state employees by not covering room and board for SUD.
I feel very strongly about that with the state of everything now I think it's unconscionable for us not to cover that.
I know I know also that that's on the Segal page of things, but I would on each one of those, I would like to know a little bit more about I can do that one on one with Segal or if maybe no one else is interested in that.
I want to see how they came up with the figures of $2.1 million to cover that.

>> CHAIR PROFFITT: We'll get in that discussion at the very next time we turn the page.

so as I said, for action item discussion item 5, we'll come back to that and talk about the financials and what the next steps will be and how we do that going forward.
No other discussions on this particular component, why don't we move back to.
Commissioner Dechant.

>> STEVE DECHANT: Have there been inquiries about am I covered.
I doubt there's data, so what's the word, scaping me now, just people remembering, just curious if there have been any queers to SEHP.

>> CHAIR PROFFITT: About the swing bed coverage.

>> STEVE DECHANT: Yes, I'm sorry.

>> CHAIR PROFFITT: We can go back and look.
I don't believe the staff has gotten in I calls, certainly we something we can go back and review.

>> STEVE DECHANT: The thought came to my mind as you made the comment, at the time it was the right decision.
Maybe things have changed and something we should look at.

>> CHAIR PROFFITT: I would agree and Commissioner Schmidt, I think we are very closely aligned as it relates to mental health coverage and making sure we are taking care of that, whether it's you know my feelings on Medicaid expansion, not to get into a different discussion, but for state employees as well, the fact we are an outlier, we shouldn't be.
If you rewind the clock six years, I don't know that we would be an outlier as it relates to these conversations, that, yes, there is coverage now, no, there wasn't the level of coverage several years ago, my comments on this taking us back to the time as which the decision was made, a different landscape, today is a new landscape.
I want to make sure we focus our effort and energy of doing what's right 2024 and going forward.
That's where I'm coming move back to tab 5. I believe we stopped at page 63 was the last page.
Maybe.
Just go to page 64.
So this is the file printout of the file used last time as we made plan design changes.
This is where we look at what the employee and increase for contribution might be on a percentage basis, the employer both for state, nonstate, Non Medicare retiree.
At the last meeting we made the determination we would not increase employee contributions for 2024, I believe the motion was for 2025.
Then you can see what the out years would be with the current forecast.

so would be the page we look at going forward.
The if you move to page 65.

>> BRENDA LANDWEHR: What page does this start on.

>> CHAIR PROFFITT: 64.
Which is in tab 5.

>> BRENDA LANDWEHR: You went back, thank you.

>> CHAIR PROFFITT: Yes, ma'am.
If we move forward to page 65, want to make sure we set the table for this and have Segal keep me honest.
This is the table that we will show or the pages we'll show, so as you have requests for items to review the financials for what it would be to cover, increased coverage, reduce coverage anything, we have a table that looks like this for each of those questions.
So if I start at the very top, section, the legislative pilot programs, terminating pans and pandas coverage, you can see across 25, 26, 27, 28, what this means is if we took that action to terminate pans and pandas coverage, the numbers across there would be the impact to the cost of the plan, meaning if we terminated pans and pandas coverage for plan year 25, the cost of the plan would go down by $210,000 in 25, 222 in 26, 234,000 in 27 and 247,000 in 28.

let me be Crystal clear, this is not the recommendation.
This is because we left it in for plan year 24, should the hcc choose to make a different choice for 25, the other choice would be to remove it and you would be saving this level of money, by having it on here, we are not suggesting we should remove pans and pandas, that's the level of the impact.
Same with terminating Amino acids formula coverage.
Next section down, dental benefits, we had some discussion at the last meeting on orthodontic lifetime max, there's a series of different options there and what the cost should be should we choose to increase the lifetime benefit.
Residential treatment, all plans, this year is including room and board benefits to current coverage, adds residential treatment for mental health and for medical health.
For some of those facilities I talked about, maybe the longer term, we don't provide residential room and board, if we determine we are going to include those, there would be a fiscal impact associated with that.
I want to come back to that one.
If moving down, if we increase the deductibles, what would the impact be on the plan, a negative number means the cost would go down.
A positive means the cost would go up to the plan.
As we make all of these decisions, you know, we'll have yes, no, roll back to the front page and see what the employees and employer contribution might be in the out years and see what the impact on the reserve is so we can make an informed decision in June with all of the plan design changes so we can see the cumulative effect of all the changes the commission wants to make.
That way we are not doing one offs throughout the year.
That's the intent of the June meeting and to make sure we have everything on one page.
If I can go back to residential treatment all plans on this page, again, the third blue box down I believe the numbers need to be updated for June walk us through what we are looking at here if you have that information.

>> KEN: Right now, these are rate manual related numbers, but we have been getting clarifications from Blue Cross and Aetna of your own experience and their book of business experience and we are going to adjust the numbers to be more in sync with their local experience.
Which has more of their contract rates and who they're contracted with.
So I believe the number will be approximately about half of what this number is here.
So it will get lower.
Less of an impact.

>> CHAIR PROFFITT: Mental health, and the medical side as well.
Overstated by about double by now.
We need to firm those up and have a high level confidence of those numbers in June.

>> BRENDA LANDWEHR: Is it also possible to on that to get a breakdown because we know the limitations we have on in patient beds in Kansas is in state, versus out of state and then where these services are being provided, what facilities?

>> KEN: I believe Blue Cross can tell us for their network as well as Aetna how much is in state and out of state, their normal book of business in a similar network.

>> BRENDA LANDWEHR: Break it down by facility?
I don't know how many in patient facilities Kansas has available.

>> KEN: They should be able to break down their experience and tell us the split of their book of business that covers that benefit right now.

>> BRENDA LANDWEHR: Who the facility is?

>> KEN: I don't see why they couldn't.
It's their book of business, I would think so.

>> CHAIR PROFFITT: Directory Flory.

>> JENNIFER FLORY: We will ask Blue Cross if they can provide us the names of the in state facilities.
I don't know on the out of state how complete that might be because there are many residential treatment providers outside of the State of Kansas and our employees may not be using like those on the East Coast probably are not going to be frequently used by our members.
But we can certainly get the in state and see what we can get on the out of state.

>> BRENDA LANDWEHR: Probably are with surrounding states.

>> CHAIR PROFFITT: Yes.

>> BRENDA LANDWEHR: Not looking for east or West Coast.
If there's something like that happening, we need to know, the costs would be higher than what we are dealing with here in the Midwest.
We do know there's facilities that individuals are going to that are outside of Kansas, it will give us as a state the idea of what it is we need to actually do or not.

>> CHAIR PROFFITT: To clarify Directory Flory, please bump me on track if I get off track as it relates to some of these services today, we do   we this qualified provider types, licensed provider types, we will pay for the medical components or the treatment components, it's the residential in patient room and board that does not get covered.
Want to make sure we are there.
If we do move to cover this room and board for residential treatment facilities, as I understands it, these are global billing and global payments that happens, so it's not going to be parsed out between the providers and the inpatient.

>> JENNIFER FLORY: That's going to vary somewhat some facilities use a global fee because they have in house providers, other facilities may be using licensed professionals who bill separately.

We do pay those separate bills today and so potentially we could be picking up some provider costs in the global fees for those that don't today.
We still may have individual providers out of state billing us directly.

>> CHAIR PROFFITT: Okay.

>> BRENDA LANDWEHR: The question is, is there a difference in the terminology of residential versus inpatient in a hospital.

>> JENNIFER FLORY: Yes, there is, it's based upon if you look at the definitions and how the facilities are licensed in patient facilities today have acute licenses and so we are covering the room and board there today in the residential facilities they have a different license and we are not paying that room and board charge.
If they are using skilled licensed professionals and they will bill us separately, we do pay those mental health services which can include group therapy, individual therapy, there's different things that they may be getting, for facilities to however may use a component of counselors like a drug counselor or a they are not licensed so they don't bill separately they under the facility as a global fee.
Does that help?

>> BRENDA LANDWEHR: It does help.
It leads me to where I'm headed.
There is a difference between inpatient with acute care and residential facilities.
I think that in order for the board to make a clear decision, we need to understand what do those definitions include, who do they include?
Who do they exclude?

>> CHAIR PROFFITT: That's going to be part of the materials that will be presented at the June meeting to make sure we have a very clear understanding.
This is words matter with this.
Commissioner Schmidt?

>> VICKI SCHMIDT: Yes, I wanted to add that it's my understanding that when we do have mental health inpatient centers and that the room and board is covered because that is usually there's a different medical component associated with that, and then many times, not all the time, but many times you step down into inpatient hospitalization, you step down to a residential treatment center, that's when we are currently not pawing that.
Mr. Chairman, I wanted to ask, I know that I can think of one time, anyway, where the commission decided to start covering the services middle of a year of a plan year and didn't wait.
I know we are not at that discussion point now, but what I would like to know is would it be possible to, if the I know, I'm part of the commission, if the Commission were to decide to they wanted more immediate coverage than to wait until January of 2025 for this particular item, I know we have worked with our partners before at Aetna and Blue Cross to make that happen, and would that be a possibility if like we wanted a September 1 start date or something like that.

>> CHAIR PROFFITT: Thank you for the question.
You didn't ask for this, but my intent is to have all plan design discussions at the June meeting, none of them today.
I know you didn't ask for that.
Just to make that clear.
My initial intent is to try to keep everything as clean as humanly possible.
We do everything on a plan year why basis so the goal is to have everything start on a January 1 start date with the plan year, it's standard practice, keeps everything clean and keeps mitigates confusion and 1346 the things that could happen when you start adding different mid year changes.
Is it possible to do a, quote, mid year change or partial year change, yes, but there are notice requirements we would have to adhere to, we would of to make the determination, stick to the notice requirement, get the communication out, make sure everybody is up to speed.
So you're buying maybe a three month window of doing that at the risk of potentially missing something along the way.
You have to weigh the pros and cons.
I don't want to say make a number of September 3, we start coverage and that person goes for treatment and it doesn't happen as planned.
We weigh the pros and cons, is it possible?
I do not believer it would be possible for us to adjust member rates.
If it is possible, I wouldn't want to adjust member rates.
Fefull freight of that cost would be borne by the state.
We do have a dual mandate for providing the best possible coverage for our employees while also managing the state's pocketbook, those are the considerations we have to take into account.

any other questions or discussion?

Commissioner Dechant?

>> STEVE DECHANT: On the Plan C section on page 6565.

>> CHAIR PROFFITT: Is your mic on.

>> STEVE DECHANT: Thank you.
When do we find out from the feds what requirements for qualified high deductible might apply?
My eyes fall on the increasing the deductibles, we have increased those for a number of years, not because we chose to, but it was a mandate.
When do we find that out.

>> JENNIFER FLORY: Usually is announced but the I.R.S. some time over the summer.
You're correct, we have kept the total, the family deductible the same, but for family contracts, because of changes the I.R.S. has made, we have had to increase that first deductible on a family contract to meet the requirements, and I think it's is it July we have seen them typically.

usually around July.

>> STEVE DECHANT: A likelihood in June we won't know what mandate there is in that regards and have to deal with it when it comes.

>> JENNIFER FLORY: That's correct.
We have to make that adjustment in August at the August meeting, but it's a compliance situation.

>> STEVE DECHANT: I understands.
If I was thinking right, wanted to draw that to our attention, it would be out there and we would have no control over it.

>> CHAIR PROFFITT: Any other comments or questions.
Commissioner Schmidt?

>> VICKI SCHMIDT: I appreciate the additional information from Segal on the overall plan richness for employee.

>> CHAIR PROFFITT: are you in the appendix for follow up materials?

>> VICKI SCHMIDT: It's in reference to on page 65 to the drug coverage.

>> CHAIR PROFFITT: Okay.

>> VICKI SCHMIDT: Is that all right.

>> CHAIR PROFFITT: Yeah.

>> VICKI SCHMIDT: Yeah, I'm back on 103 and 102 and stuff I know it can be small percentage points, but our Plan A isn't as rich as some of our neighbors, so to speak, but when I look at page 105 and 106 and look at our the regional plans, how Kansas compares to Nebraska, Oklahoma, Missouri and Colorado and Iowa, our drug plans, our drug copays are significantly higher than any of our surrounding states.
And that does bother me a Tad.
I think we have I'll be submitting some questions possibly I will be on decreasing some of those copays and seeing what that does to the numbers, but I mean, you know we are at 20 percent coinsurance, which is a lot different than a five dollars copay, ten dollars copay, 20 or and on preferred brand drugs, we are really our employees are paying much, much more than they would in surrounding states.
I know that would contribute to the richness enough your plan, I don't know how much, but I know it would contribute to the richness of our plan.
Just wanted to make that notation.
Thank you.

>> CHAIR PROFFITT: Thank you.
And you had gotten ahead of me, into tab 9.
That's all right.

We are good.

a good way to move us forward.

any other questions or comments?

all righty.
So that was the   since we are there the follow up materials on tab 9, appendix a, few questions about health center utilization.
Review the data there and the benchmark follow up and the plan richness we discussed, if there's any questions there.
Commissioner Dechant.
>> STEVE DECHANT: When I looked at those,
>> Prove which page are you on.

>> STEVE DECHANT: 105.
Same thing Commissioner Schmidt was referring to.
When I looked at those, the question I had, how does a percentage coinsurance compare to a five dollars or 14 or whatever it is, can we calculate what our 20 percent coinsurance is in dollars versus percentage?
How can   you made the statement, I have nothing to say, you are correct or spot on or whatever, but.

>> JENNIFER FLORY: We can work with care mark to try to do some modelling to see if we can come up with that.
You know, our plan is a transparent pharmacy program with point of sale rebates, which come into play when a member purchases particularly a brand drug that would have a rebate ask, that's applied at the point of sale, reducing the dollar amount before the coinsurance is applied which is a very progressive program which I can tell you many states would be very pleased to have but it is very difference for a flat copay amount.
We can see if we can work with care mark and their team to see if we can do some modelling on that.
Another thing a that potentially the commission could look at.
If they are interested, would be on our high deductible health plan, we don't   all of our drugs are subject to the deductible today.
There is a preventive drug list that is allowed a qualified plan could have, and those drugs would either could have a lower deductible or they could have no deductible and just have the coinsurance applied.
So there are some options we can look at within that.

>> VICKI SCHMIDT: I don't understand what was just said.
Rebate is applied before the coinsurance.

>> JENNIFER FLORY: Yes.

>> VICKI SCHMIDT: How is that transparent, if that   how does a consumer know what rebate you got before you got the 35 percent coinsurance hit?

>> JENNIFER FLORY: It's transparent in that if I am taking a drug that cost $100 and there's a $20 rebate.
That is applied at the point of sale, reducing the amount I have to pay out of pocket.
Both the state and member benefit from they rebate at the point of sale then it is applied both sharing at the lower rate.
As opposed to what most states do, which is instead they take that $100 and apply the copay to it.
A check for rebate comes and is put into the health plan account.
So it's transparent in that the rebates the member is actually earning with their purchase are actually applied to their purchase and they benefit from them.

>> CHAIR PROFFITT: That's to say in the example of a $100 medication, $20 rebate, as opposed to paying the coinsurance on $100, it is reduced off of $80 instead of $100, instead of paying the full freight and waiting for a rebate check to come back into the state.

>> JENNIFER FLORY: The member doesn't directly rebate from that rebate check that comes back to the state.

>> CHAIR PROFFITT: They do get the benefit of the reduced base on which the coinsurance is placed.

>> JENNIFER FLORY: If we didn't have point of sale, the money would come back to the state.
It is applied at the point of sale and then we do a true up at the end of the year, so if there are any rebates that actuals are different from the estimates, those dollars do go into the state fund as part of the income in the account.
If you're a copay plan, the entire rebate amount goes into the plan as opposed to the member who actually generated the rebate.

>> CHAIR PROFFITT: Commissioner Schmidt?

>> VICKI SCHMIDT: I'm talking about the transparency of the patient this is a big complaint about pbm's, the t word, transparency word.
So the patient picking up the prescription, never knows about the rebate.
I don't ever see that receipt.
>> JENNIFER FLORY: That's entirely possible.
As the rebates do change we hear from employees, is going to go off of patent, then they will see that there rebate dollars reduced and their yes, you are correct, it is not going to show you benefited from they rebate.

>> VICKI SCHMIDT: I do have a problem with that because.

>> CHAIR PROFFITT: What would be the recommendation Commissioner?

>> VICKI SCHMIDT: That the receipt to the patient ought to show the transparency of what the rebate was.

>> CHAIR PROFFITT: Do we have the authority.

>> JENNIFER FLORY: I don't know that we have the ability to do that because you're talking about receipts generated at a pharmacy and there are many pharmacies and they don't all use the same system.
I don't know.

>> VICKI SCHMIDT: Still all use point of sale.

>> CHAIR PROFFITT: Let's take it as a follow up item.
I can't commit to an answer by June.
Point well taken.
I would anticipate seeing all the what led to the cost.
Let us determine what options are available to us and from there determine the best course of action.

>> BRENDA LANDWEHR: Mr. Chairman.

>> CHAIR PROFFITT: Commissioner Landwehr.

>> BRENDA LANDWEHR: I could see the complexity with the receipts, where do we see it in our financials?

>> JENNIFER FLORY: We do on an annual basis a true up with care mark, and we get the total dollars that they've paid out in rebates, total dollars that were earned and in any difference between those dollars is given to us in the form of a check and shows up in the Segal financials.

>> CHAIR PROFFITT: Separate line item is that broken out as a separate line item.
Seeing heads shaking?

can you on the microphone, please.

>> KEN: We have them separate.
We can break them out.

>> CHAIR PROFFITT: If we can break them out, that would be helpful to see what the rebates are.
Thank you.

>> BRENDA LANDWEHR: Thank you, Mr. Chairman.

>> CHAIR PROFFITT: Commissioners, we are 19 minutes over.
Any last items?

as a reminder, next meeting will be June 3, so we need by May 10 any requests for anything you would like Segal to model for potential plan year 25 design changes, we'll make sure that we have all the wording and the appropriate levels of care broken out as it relates to residential treatment.

We'll have a good robust discussion there, if there are any comments or questions or requests for improvements in advance of the next meeting, with levels of specificity that will help us drive to a good resolution, help us provide those in advance, I want to thank staff for all the time they put into this.
I know you work incredibly hard.
I appreciate you coming prepared and keeping us prepared and answers our questions.

>> VICKI SCHMIDT: I would entertain a motion to adjourn.

>> CHAIR PROFFITT: So moved. Is there a second?

>> ANTHONY HENSLEY: Second.

>> CHAIR PROFFITT: All in favor,
[chorus of ayes]
Any opposed.
We are adjourned.