

ROUGHLY EDITED TRANSCRIPT  
KANSAS STATE EMPLOYEES HEALTH PLAN  
HEALTH CARE COMMISSION  
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>> CHAIR PROFFITT: Are we ready for a motion.  
Commissioner Cain?

>> CRISTI CAIN: I would like to make a motion that we move forward with the itdm contract.  
>> CHAIR PROFFITT: For three years.  
>> CRISTI CAIN: For three years.  
>> CHAIR PROFFITT: Is there a second?

>> Second.  
>> CHAIR PROFFITT: Is that is second, Commissioner Dechant.  
>> STEVE DECHANT: [ no odd ]

>> CHAIR PROFFITT: We have a motion and a second, is there discussion on the motion?  
[ no audio ]  
any discussion on the motion?

>> This should be interesting.

>> CHAIR PROFFITT: Okay, hearing none, Commissioner Cain?

>> CRISTI CAIN: Aye.

>> STEVE DECHANT: Aye Commissioner Hensley.

>> ANTHONY HENSLEY: Aye.

>> CHAIR PROFFITT: Commissioner sought sun

>> WILLIAM SUTTON: Aye.

>> VICKI SCHMIDT: Aye.

>> CHAIR PROFFITT: Motion carries.

we'll stand at ease for a few minutes until we can try and figure out the audio.

>> Sir, we have audio now

>> CHAIR PROFFITT: All right.

Speak the microphone to test to make sure the folks online are able to hear.

I'll stop talking for ten seconds and make sure there's no delay in the room.

I think we are in good shape here.

I'll test this one more time.

We have a Commissioner on the phone a staff member.

Here in about ten seconds we should know if we are still available online.

yeah.

all righty, we are going to come back to order, I apologize to everybody in the room and online.

Hopefully we have everything worked out.

Thank you, team, for working through that.

Just to make sure we recap for those that are online, we call ourselves to order, approved the minutes from the August meeting, we just wrapped up approving the map membership administration portal contract for the next three years.

And I think we are in good shape.

We are ready to move on to the next agenda item.

With that, we'll talk about the EAC appointments, I'm invite Michael Lundin to come up.

Hopefully the microphone works.

if you can introduce yourself for those online.

>> I'm Michael Lundin, President of the EAC.

Do we have a slide?

thank you.

We've -- over the past several years -- yes -- with have seen some attrition in our membership due to

retirements and resignations for people leaving to go take other positions, and so we have had a very successful recruitment drive for new members, a wealth of very qualified candidates, and our committee for membership has reviewed many applications and come up with a list of recommendations for seven new members to fill vacated positions, including one retired member.

There is an open retired member position.

And additional three reappointments of current members who are up for renewal.

I will refrain from butchering their names.

But you can see them in the memo.

So I would ask -- obviously this is a recommendation to you guys and ask for your approval of those new members.

>> CHAIR PROFFITT: Very good, thank you very much.

Commissioners, any questions?

Commissioner Dechant.

>> STEVE DECHANT: Remind us please the total membership number of EAC is.

>> Michael: I believe it's 21.

>> CHAIR PROFFITT: Commissioner Schmidt.

>> VICKI SCHMIDT: I move to approve the recommendations for the seven new members and also the reappointment of the three members.

>> Second.

>> CHAIR PROFFITT: We have a motion and second from Commissioner Hensley, any discussion on the motion?

Hearing none, Commissioner Cain?

>> CRISTI CAIN: I was just going to offer a second.

I was too slow.

>> CHAIR PROFFITT: voting on motion now.

>> CRISTI CAIN: Aye.

>> STEVE DECHANT: Aye.

>> ANTHONY HENSLEY: Aye.

>> BILL SUTTON: Aye.

>> VICKI SCHMIDT: Aye.

>> CHAIR PROFFITT: Motion carries, thank you very much.

>> Thank you, Commissioners.

all right, that concludes the action items component of the meeting, we'll move on to discussion items, Director Flory will walk us through the open enrollment report.

We should be on tap for.

>> JENNIFER FLORY: Okay, Pete, can we advance one more.

So we did complete another open enrollment successfully.

On the next slide, we'll look at the active employees starting here.  
The so you can see on this slide we've shown you the playing year 2025 enrollment.  
In the middle column and on the left of that is the plan year 2026 enrollment.  
And for the most part, except for two items, we have seen increased enrollment.  
We did see a less select the mass transit benefit, but a few more picked up the parking.  
And then when you look at the HRA, we have a fewer number of members this next year, just a slight reduction in the number of members who elected to have a health reimbursement account.  
We did see that the number of individuals with a health savings account increased.  
So we're going to look at these numbers in more detail in just a minute.  
We did also see a slight increase in the number of employees who did not -- who did not go out, they were currently enrolled in plan year 2025 and in 2026 didn't take action so they will be defaulted to Plan N.  
Slight increase in the number that defaulted.  
So on the next slide, open enrollment began October 1 and ran through October 31.  
Our staff am conducted seven virtual personnel officer training meetings and those were available to the HR staffs of all the state agencies, the noncabinet agencies and the nonstate public employer groups.  
We held two benefit fairs at the capital, we held one outside and one in the rotunda.  
We had four live open enrollment webinars and staff connected 44 open enrollment meetings in 24 cities throughout the state.  
In addition, on our website, we have a video of open enrollment presentation that was available 24/7 to any employee who wanted to watch it.  
We also had vendor specific -- vendor specific videos available on our website.  
As well as the open enrollment book.  
So on the next slide we'll look at a summary for the state employees.  
We had 35,503.  
On the nonstate public employers, we had 3,189 enroll.  
Plan A has the highest enrollment with 19,462.  
Followed closely by Plan C with 16,282.  
Plan J, you'll recall, this is the plan that is specifically designed to meet the needs of an individual who is in this country on a j1 Visa.  
It is available to any employee who wishes to enroll in it.  
It is expected that it has a small enrollment.  
And then Plan N is our most affordable product, has the lowest premium but does have additional out of pocket costs. That enrollment at 2,380.  
On the next slide, you can see the breakdown between Blue Cross and Aetna.  
Aetna 4,372 contracts, which is a slight increase over their current number.  
And Blue Cross Blue Shield has 34,320.  
And on the next slide, you can see the breakdown, we had 546 individuals who has Aetna, moved to Blue Cross and 402 who had Blue Cross to move Aetna.  
On the next slide, you can see the enrollment by the different plans broken out, you can see how many people took Blue Cross and how many took Aetna for each of the plan offering.  
On the next slide, we break it down so you can see what type of contract did the employees take, and, again, the vast majority have enrolled in employee only coverage.  
Followed by employee and children, family, and finally employee spouse.

then we break down on the next slide dependent numbers are a little bit further and show you the state versus the nonstate, and how many spouses are covered and how many children are covered and the totals for all dependents covered.

On the next slide, we have the dental, you can elect that separately for medical.

An individual who has coverage somewhere else for medical can elect to have dental.

We had 39,528 contracts in the dental.

Our voluntary prescription eyewear insurance, this is our voluntary plan that is the premium entirely paid for by the employees, we offer two options, basic program and an enhanced plan, the big difference is the enhanced plan has better coverage if you are using bifocals, your no line bifocals and some of the higher cost lens options.

It is always the most popular with 22,728 people selecting it.

The voluntary insurance coverage, these, again, are entirely employee paid contracts, this is insurance that is available, we offer an accidental injury plan, critical illness and hospital indemnity and over the last few years, we have seen the popularity of these particular options continue to increase.

on this next slide, we look at our account based programs, individuals on Plan C and Plan N, the health savings accounts, 17,336, the most popular option.

And only a few folks have selected the HRA at 1,330.

We also offer the flexible spending accounts.

This allows our employees to set aside money pretax from their check in order to pay for health care expenses.

The health care FSA can be used by individuals on Plan A and j, as well as individuals on Plan C and n who have an HRA.

So that is the most popular of the accounts, with 6,532 members selecting it.

For an individual who has an HSA, they are limited to having a limited purpose FSA, which covers dental and vision expenses.

Dependent care is for individuals who have children that are getting daycare type expenses, and they can set aside pretax premium dollars to help pay for those child care expenses they are incurring.

the commuter benefit, two different options within this, we have a parking option that allows our employees who are parking in mostly public lots or privately owned lots close to their offices to set aside the cost of that parking out of their check pretax, the mass transit allows the individuals particularly who use public bus services or on the state can set aside their costs for the transit costs using that mass transit benefit.

And on the next slide, again, this is about the individuals who got defaulted to Plan N, these are individuals who were enrolled for coverage in plan year 2025, but -- yeah, 2025 but did not go in and make a selection for plan year 2026.

So they would have been moved to Plan N, if they were enrolled with Aetna, they remained with Aetna, if they were with Blue Cross, they remain with Blue Cross.

Plan N is our most cost effective program, lowest premium for those individuals, they are set up with an HRA.

Will so this year we did have 347 individuals that got defaulted, 96 of those were already enrolled in Plan N to begin with.

And we have 307 of them were state employees and 40 of them were nonstate public employees. And with that, I will stop with the active and secretary, you can give me direction on how you want me to go forward on direct bill, go through all of that.

>> CHAIR PROFFITT: Pause here and see if Commissioners have any questions.

>> VICKI SCHMIDT: On the last slide on page 34 decree employees defaulted to Plan N, I don't think this reads as clearly as I think it should.

On the first bullet point -- the second one under the employees not -- that were enrolled in plan year.

The first bullet point, enrolled into the same health care company, I get that.

And the same coverage left field because that isn't really the same -- if they were enrolled in a, we didn't re-enroll them in n.

>> JENNIFER FLORY: What we meant by coverage level.

What we mean by coverage level, if you had family coverage this year, we defaulted you to Plan N with family coverage next year.

We didn't reduce the level of your -- or the eligible members covered.

So that's what we intend by this.

So we could work on how we phrase that.

But that's what we need.

If you had someone covered, you didn't lose coverage for that person.

>> VICKI SCHMIDT: Understand that, thank you.

>> CHAIR PROFFITT: Any other questions, Commissioner Dechant.

>> STEVE DECHANT: Just several.

Any idea how many employees attended either the live or video open enrollment presentations that were made?

I don't need a direct number, just a sense of how well or slimly that was utilized.

>> JENNIFER FLORY: If I roll back here to the open -- the annual report, we do have a section in the annual report.

>> STEVE DECHANT: You're going to call me out for not having read the annual report.

>> JENNIFER FLORY: In here, we talk about open enrollment and over 500 members attended the first event outside the capital.

The second event in the rotunda saw over 350.

The staff had 44 meetings at 31 locations in 24 cities.

These meetings were attended by 2,700 members in total.

Does it tell me that?

>> STEVE DECHANT: Okay.

For me that gives me a pretty good idea.

Pretty good attendance.

>> JENNIFER FLORY: It actually is -- to summarize for those of you who have the annual report, on page 114.

Very.

>> STEVE DECHANT: For years our enrollment has been a small percentage of the overall enrollment, that doesn't cost us -- that is the health care system, any more to have two separate

companies involved or what costs, if any, are there to us.

>> JENNIFER FLORY: We view it as a benefit to having two vendors because it allows us to, like, for example, right now we have an issue here in the City of Topeka that Blue Cross & Blue Shield and one of our main hospital systems, campus of St. Francis have not reached an agreement on a contract.

We do have that campus covered under Aetna.

The so employees were made aware that if they were concerned about having that coverage, that it would be available to them if they chose to enroll in Aetna.

Keep in continue mind Plan A is Plan A, doesn't matter if you get you it from Blue Cross or Aetna.

It is the exact same coverage.

The difference is the network that they have available.

So we see that as one of the big benefits.

It really doesn't create a lot of extra work to have two vendors.

Because the plan design is the same.

If the plan designs were different, and we had to administer different programs with the different companies, that would be more challenging, but this is -- you know, when I started with the health plan, I think we had 12 companies.

We had like three PPO's and like eight HMO's.

By comparison today, this is pretty easy.

>> STEVE DECHANT: I don't have an ulterior motive just instruct me as we were going through things.

By the way, Hutchinson had an issue with Blue Cross and the health clinic there has been resolved.

Same kind of thing existed for a while.

Dental must be maintained.

If I drop dental, I won't be able to get back in again, correct?

>> As a retiree, that is a correct statement.

>> STEVE DECHANT: How about as an active.

>> JENNIFER FLORY: They are allowed to pick every year during open enrollment whether they want to maintain dental coverage.

>> STEVE DECHANT: I can dip in and out as an active.

>> JENNIFER FLORY: Yes, we don't see a lot of people actually doing that.

Most people, the dental program is a very good program, and they want to go get their two plans per year, because they get their credits for their health class, getting their dental cleanings.

That's an easy way to get credits toward your wellness benefits.

We don't see a lot of movement in that.

And the disconnect between dental and medical was really more about allowing individuals who particularly had medical coverage either through a former employer, the Federal Government, or through V.A. benefits or somewhere, to be able to select our dental plan.

That was a big request we got.

>> STEVE DECHANT: I notice there's about 1,000, maybe 800 more folks enrolled in dental than in the medical.

>> JENNIFER FLORY: Yeah.

>> STEVE DECHANT: What are the costs when we -- are there costs to maintaining the flex

spending accounts or the costs of basically on the setup when they're created and then the maintenance just is an ongoing thing with little or no cost.

>> JENNIFER FLORY: Yeah.

There is a fee for the FSA's for the setup. This year, but next year when MetLife takes it over, remember they had no fees when you voted on that contract.

There will be no fee for it.

The other big benefit to the state, when this employee elects to use the pretax dollars, it reduces the employee's taxable income, but it also reduces the state's fica tax.

That's the benefit to the state, reduction in taxable income reduces the fica tax, which has been a huge benefit to the state.

>> STEVE DECHANT: Thank you.

>> CHAIR PROFFITT: Commissioner Schmidt .

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

Has staff ever done a side by side comparison on Aetna and Blue Cross Blue Shield on what you say is very are the same exact benefits?

>> JENNIFER FLORY: The benefits in the benefit description are exactly the same.

The there may be some cases where if it's such as a situation where you're looking at a surgical procedure, that Blue Cross may not consider that to be, you know, the standard of care, and Aetna May, because they do have their own medical experts on staff that would come into play, but as far as the benefit main structures, they are the same.

>> VICKI SCHMIDT: I know of an example where -- I don't know whether -- it wasn't a surgery, but it was a treatment where the -- one plan covered it and the other plan did not.

>> JENNIFER FLORY: That could be because they each have their own medical criteria that they use for making decisions on -- particularly on services and what is the standard of care.

The they each use their own experts to determine that.

>> VICKI SCHMIDT: I think that would be -- I think that would be important for our employees to know, if -- but when they enroll.

Does -- what does Aetna cover and Blue Cross Blue Shield cover.

They aren't the same.

>> JENNIFER FLORY: Unfortunately, I don't know that that's going to be something that's going to be easy or maybe even possible to compare because there are so many procedures, that potentially might be impacted by those types of medical decisions.

>> VICKI SCHMIDT: I don't think we should say they are exactly the same because they are not the same .

>> JENNIFER FLORY: The base structure is the same, potentially there is variance on what they consider standards of care and what services might be considered experimental or investigational.

>> VICKI SCHMIDT: I think we need to put that in it when we say that because -- they're not.

>> JENNIFER FLORY: Okay.

>> VICKI SCHMIDT: Thank you.

>> CHAIR PROFFITT: Any other questions or comments?

okay.

Jennifer, why don't you just very quickly just hit on the highlights for the direct bill the next couple of pages.

>> JENNIFER FLORY: So Pete, can we go forward to direct bill.

So Non Medicare eligible members enrolled through the direct bill program, we had -- so one big difference between direct bill and active employees, active employees we have active enrollment.

That means you have to go out and make an active election or you get defaulted to Plan N.

With our retiree population, their coverage rolls from year to year unless they actively decide to make a change.

So if I am a Non Medicare eligible person, and I am enrolled in Plan A and I don't want to make any changes, I don't have to do anything and my coverage rolls forward.

The numbers showing here are the individuals who actually went in and made some sort of change during this open enrollment.

So for clarity, these are only folk who made changes, 499 of them.

You can see Plan C was the most popular option that they chose.

The so let's go forward.

So here you can see for our Medicare eligible population, again, these individuals don't have to make elections, but this breaks out the total contracts here.

You can see that we had 667 -- 6,677 who are enrolled now in Medicare Supplement insurance.

And we have 749 low have elected Medicare Advantage plan.

Direct bill members do have the right to go in and if they are covered under a Medicare Supplement plan in 25, and they want to move to Medicare Advantage in 26, they can do that.

If they are enrolled in Medicare Advantage in 25 and want to go back to a supplement plan, they can do so during open enrollment for plan year 26.

They have the same rights that an active would have with regard to covering their family members and making elections about their coverage.

And I think respect let's go one more, Pete.

So this just shows you, this is how many of our direct bill members have elected dental.

We have 8,216 contracts in the dental.

Of our direct bill members, 5,027 have elected the prescription eyewear coverage.

So I think that pretty much covers direct bill.

There's additional information further back if you want to see what the numbers look like year to year between the plans, we have all those slides in the back for you.

>> CHAIR PROFFITT: Thank you.

Any questions on direct bill?

Commissioner Schmidt.

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

What I'm wondering is, I did not realize this until recently, but if -- if a 65-year-old retires from the State of Kansas and goes on med care -- Medicare but has a younger spouse that's like 60 years old and still want to have insurance, that spouse can enroll in our State Employee Health Plan, right.

>> JENNIFER FLORY: As long as the Medicare eligible person is covered by the State Employee

Health Plan, then the Non Medicare spouse is also eligible to be covered.

>> VICKI SCHMIDT: Why does that not -- why does that Non Medicare eligible spouse, why are they allowed to join at the employee rate?

Because one of the big deals that we have had discussions on ever since I've been on this commission, seven years now, is that the spouses are the expensive ones, right?

I mean that's what -- that's what Siegel tells us. What would we allow them to enroll as an employee and not at the level of the employee plus spouse level?

>> JENNIFER FLORY: So when a member becomes Medicare eligible and they are not an active employee, the decision was made that we would move all of those members, whether it's the employee or the spouse, whoever is Medicare eligible, must pick a Medicare product. So we split the enrollment, so we set it up so we track them together, but the Medicare person picks from the Medicare column and the Non Medicare person picks from the direct bill Non Medicare products.

They pay both the employee rate and the employer rate.

It's a combined rate.

It's not -- they don't get it for the same price that you get your coverage as an active employee, that spouse would be paying the full cost of the insurance.

Just like an employee who retires pays the full cost of the insurance.

>> VICKI SCHMIDT: But we set the other plans up that your spouse -- if you want to cover your spouse, it's a lot more expensive than just the employee only.

The so I'm just asking, I would like to revisit why we have -- why we allow these Non Medicare spouse to enroll at the employee level?

>> JENNIFER FLORY: We would have to look into -- work with Segal, if that were to be something the commission wanted to develop separate rates so employees and spouses pay different rates as direct bill.

Yeah.

So o I don't think I have a better answer.

>> VICKI SCHMIDT: Could you do the research to tell us.

>> JENNIFER FLORY: Yeah.

>> VICKI SCHMIDT: How did that come about?

>> JENNIFER FLORY: The commission did vote to go -- back up.

Back.

>> CHAIR PROFFITT: Might be better served to put a pin in this and have an offline conversation.

>> VICKI SCHMIDT: 100 percent.

I think it's important.

>> CHAIR PROFFITT: I don't want to get into speculation.

If we can connect offline, we can make sure to follow up at the next meeting.

Not trying to kill the conversation.

>> VICKI SCHMIDT: I request that we get some -- that everybody gets some answers on that as to how we arrived at that decision.

>> CHAIR PROFFITT: We'll have Jennifer connect with your staff and make sure we are answering

the right question and the team will do the research.

>> VICKI SCHMIDT: Also, if you can delineate out the cost of the knob employee being in the employee category.

>> JENNIFER FLORY: I have questions.

So we -- we'll connect and see if we can't find some answers, I don't think I followed that.

We'll get there.

>> CHAIR PROFFITT: Cover it offline and come back.

Commissioner Dechant.

>> STEVE DECHANT: I have one comment and the question is asked by Commissioner Schmidt reminded me, even though this is years back I remember when I made the switch from direct bill, Non Medicare to direct bill Medicare, and that's pretty seamless for me.

There's not a big age difference, but there's an age difference between my wife and I, it really caught me off-guard.

I got the coverage you're asking about.

I guess what I'm suggesting is, and I'm not sure the where, I guess -- probably to the employee when he or she is going from direct bill, non direct bill Medicare, to say to them, if you have a spouse who is younger or something, be aware he or she becomes a noninsured on your plan unless they make some other arrangements.

I just remember that being kind of a hectic and concerning period of time for me in that first month or so, preceding to make sure I got all the t's crossed and i's dotted to keep her covered.

>> JENNIFER FLORY: So.

>> STEVE DECHANT: It wasn't clear to me at that point -- it makes sense, but I didn't anticipate that when I became Medicare eligible and had my own plan, that my wife was then separated and I had to make arrangements to cover her whatever those rates were going to be.

I was caught unawares so I guess saying to the folks, even if you're an active employee, I guess, if you're older than your spouse, you basically get your own plan and your spouse has got to have his or her own plan as well.

>> JENNIFER FLORY: Not as an active.

As an active employee under federal law, we cannot treat a Medicare person different than we would treat any other active person.

So under the active plan, if someone continues to work past Medicare eligibility.

>> STEVE DECHANT: I'm talking about going to retire.

>> JENNIFER FLORY: For direct bill, we do split the contracts, the spouse is still an eligible person, they are split to the Medicare person takes the Medicare plan, the Non Medicare person takes the active plan, and they're billed separately, I believe.

Aren't they, Mike?

>> STEVE DECHANT: Probably so.

I may need to take a look at what I see, but I recall that time, okay, and -- it worked out, but I recall it being an anxious time for a bit because I was -- I was caught unawares that my moving to this other status separates her from what we have been doing.

So I had to -- maybe there's something that can be put in the information that throws up a flag for

people.

>> JENNIFER FLORY: We recently -- this summer we worked on at separating out the -- we have for employees what's called the employee guide book, which is kind of the rules of the road from an active employee, we had dredged in parts, information for direct bill people.

This summer we actually split those books apart and made the active books strictly address active issues and the direct bill book more specific and detailed to provide our direct bill members more information about how to navigate once you become a direct bill member.

The so we have tried to enhance that, but we can certainly go back and look at it.

>> STEVE DECHANT: Thank you.

The.

>> CHAIR PROFFITT: All righty.

Seeing no other discussion, Jennifer, I want to reference in the appendix the annual report, since Jennifer mentioned that.

That's what we will be submitting to the legislature in January as required by statute.

Just draw your attention to that.

If you've had a chance to read it or not, that's what will be going to the legislature from the commission.

All right, moving on to the financial report, we'll have the folks from Segal come up.

Before they jump into the financial report, why I believe Ken is going to discuss how they're making staffing changes at Segal and he'll go through that.

>> Okay.

First off, I want to thank the commission, the staff, everybody, it's been a pleasure working with you guys, I first started working with you in 2015.

It's now our 4th contract.

The so not only do I value it, but Segal greatly values our partnership with you.

That being said over the course of time, of course companies want you to do more roles and more responsibilities, so I've been asked to take more of a new business role for the east region.

So I'm going to -- for your account I have to be more involved as an executive sponsor, I'll be immediately responsible for your account, but we'll have a new person involved to dedicate the account management.

Kirsten is here today, we'll address you in a couple of minutes, Kirsten has tremendous experience, she's a Senior Vice President as well in the company, she manages a number of state accounts, similar to how I do it, she works nationally in a lot of the public sector resource groups, like the public sector health care round table in Washington, DC, works for the state and local government benefit association, doing presentations, a frequent speaker.

I'll let her address it.

She's very well spoken, very well respected in the industry.

That being said, Patrick has also been asked to do an additional role.

Patrick is taking a leadership role in our region.

So he's going to work closely with the actuary we are adding to the account.

I wouldn't say we are leaving, we are adding additional staff to cover your account like we have.

Melanie was the chief actuary for Texas teachers retirement system, also a Vice President, very well respected, very bright, so with that, I'll let Kirsten say a couple of words.

>> Good morning.

Nice to see you all as Ken said, jive been with Segal -- I've been doing this for 31 years, health care actuarial consulting.

I did work on this account before in 15 through 17, I've worked with Ken and Patrick for the last 18 years.

The so even though you haven't seen me, I always know what's going on here as well, because we all work together.

Myself and Melanie are looking forward to coming in here and being with you all just as Ken said, I have over 30 years of experience, I've done Medicare, Medicaid, all kinds of things.

I think actually back when aca came in, I did the projections for the medication expansion population for Kansas with a different role, but happy to meet you all and happy to be involved.

>> CHAIR PROFFITT: System thank you for being here.

>> Thank you.

>> CHAIR PROFFITT: Look forward to working with you.

Patrick would you walk us through the financial report for the final time.

>> Patrick Klein, Segal.

We have data through October, and the first table we have are actual to budget.

So the bottom line, the reserve balance, we are projecting a \$23.7 million ending balance through -- 32.7 million.

We closed at the 46.3.

That's 13 boy \$6 million ahead of what we projected.

Now you have to take into account, we had the un-foreseen pharmacy settlement of \$14.6 million midway through the year we didn't budget for.

So if you take that, we are \$1 million below what we initially projected.

On \$520 million in spend through the first ten months, that's relatively close to our numbers.

If you look at the various expense items, medical being the biggest expense at 13 -- sorry, \$315.1 million.

We are actually right on from what we initially projected.

Pharmacy is where we have the biggest variation.

\$3.6 million loss or 3.8 percent.

Dental is fairly close.

\$.6 million loss health care savings higher than we initially projected.

There was a question last time on Hough of that is HRA versus HSA dollars, and we did the calculations and it's 94 percent HSA dollars, so that drives with what Jennifer reported on the enrollment for HSA versus HRA.

Then we have some other fixed fees and accounts, and there's not a whole lot of variation there.

The so on the expense side, we are \$4.7 million behind and then we had an offset on the revenue where we had gain.

Root we come back to a million dollar loss.

Our enrollment, the left column, that's what we set our budget off of, at the beginning of the year, the head count and now that we are through October, we haven't seen much of a change, 20 contract difference, basically the same, been a little bit of a shift.

More Non Medicare retiree contracts and less Medicare contracts.

Then this table, this is our multi-year projections, so we are projecting expenses and revenues out through 2029.

And the merging experience on the medical was positive.  
We are seeing a slight decrease when we project those costs out to future years.  
Pharmacy we saw that loss.  
So that accumulates into our baseline projection.  
So our pharmacy projections are higher, dental a slight decrease.  
When you look at it all together, we are basically in the same spot as last update.  
So our projected reserve balances through the future years are really close to what we presented before.  
We did add this table at the bottom to kind of hone in on what's going on with the pharmacy.  
This is our GLP-1 spend through -- for 2024 compared to 2025 through Q3, and the top two drugs, again, for diabetes, and then the bottom two, those are your GLP-1's for weight loss.  
And in total, we have seen about \$5 million in growth in terms of net spend for 2025.  
So that's a large driver on our pharmacy trends.  
Really Zepbound is driving a big portion of it.  
I did notes notice the Wegovy, you're seeing high utilization increases.  
So 72 percent increase in prescriptions, yet the total cost is only going up 38 percent.  
So we are seeing some improved pricing on Wegovy.

any questions about.

>> CHAIR PROFFITT: Commissioner Dechant.

>> STEVE DECHANT: On the GLP-1, we took some action on that, and what impact, if any, have we seen or do we perceive?

>> That would be effective at the beginning of next year.

>> STEVE DECHANT: Hospital started yet.

>> Yeah.

>> STEVE DECHANT: Thank you.

>> CHAIR PROFFITT: Commissioner Sutton.

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

I am pretty sure I asked it last time.

What is it we are seeing between 27 and 28 that leads to a pretty decent turn-around in our reserve balance?

>> I mean, I think it's just the funding is starting to catch up. You can see the net income, net expense number, are it starts to dip down and then you're starting to climb up in 2028.

>> BILL SUTTON: But I thought that the funding level would have already come into play maybe even for 26.

>> Yeah, the funding is level.

You can see that your expenses are higher than your revenue now, but as we go further and further out, the revenue at 7.9 percent, what we are projecting, that's above your cost trends, so it takes a while for it to catch up.

In 2027, the expenses -- you can see on the on the sentence here at the top, that there's 53 medical

payments, in 2027.

There's some -- seasonality in terms of the years where -- 2027 is higher because you have 53 payments and normally you have 52, the cost in 2027 is higher than traditionally it would be because you have that extra medical payment in there.

>> BILL SUTTON: \$17 million?

Or \$24 million, actually, I guess, net income.

>> Yeah, I guess -- you can see in 2026, we start there, you have a \$12 million deficit, right, net expense.

So we move to 2027, it \$7.1 million.

If we didn't have the extra medical payment, that would be probably close to 0, because we spent about \$7 million per week on medical claims.

So I guess if that was a 52-week year, then that would be close to 0, and then you could kind of see the normal progression.

>> BILL SUTTON: Okay it's at least mud level clear, got it, thank you.

Approaches Commissioner Schmidt?

>> VICKI SCHMIDT: Thank you.

I have never thought about it in these terms before, but how are the compounded GLP-1, where do they come into play here?

>> Compounded GLP-1's.

>> VICKI SCHMIDT: If a pharmacy is compounding it?

>> I don't believe the plan covers compounded.

>> VICKI SCHMIDT: Those are all cash only?

>> Yeah.

>> VICKI SCHMIDT: Okay, thank you.

>> CHAIR PROFFITT: Any other questions Commissioners?

All right.

Seeing none, thank you, Patrick.

Appreciate your time.

>> All right, thanks.

>> CHAIR PROFFITT: All righty.

Commissioners, moving on to just hoping to get settled on a December date.

You might recall during our last meeting, we did schedule HCC dates for February, April June and August.

You can see those on, I don't know, I can't read the page number, tab 6.

But we left December open because none of the days we proposed at the last meeting worked. The hoping the second bite at the apple, we are able to get something that works for the December meeting, 2026.

Strikes me as I'm guilty as a society we are all busy 12 months out.

So in December, you can see I believe, columns are original, maybe if anything changed, we have

added some dates.

Looking at calendars, December 1, 2, 3 and 8 for the 9:30 to 11:00 slot available, or we can move to an afternoon slot, December 9 or 10.

>> For me, any except the 3 would be acceptable.

>> CHAIR PROFFITT: Commissioner Dechant removing the 3rd.

Commissioner Sutton is open the whole time, waiting for us to decide.

>> BILL SUTTON: The only date I can do is the 3rd.

>> CHAIR PROFFITT: Looking for a quorum at this point.

Commissioners, just a moment here.

Commissioner Cain, are you aware of any that don't work.

>> CRISTI CAIN: I am not aware of any.

>> CHAIR PROFFITT: Commissioner Hensley?

>> ANTHONY HENSLEY: So am I, still.

>> CHAIR PROFFITT: Fair enough.

Commissioner Schmidt?

>> VICKI SCHMIDT: I think for me the 1st, 2nd or 3 will work.

I don't think after that those -- after the 8th doesn't work.

>> CHAIR PROFFITT: Why don't we do this, target Tuesday, December 1 at 9:30.

Since that's the first one, if something comes up, we have a few fallbacks behind that.

We will set Tuesday, December 1, 9:30 to 11:00, as our December meeting.

thank you, I appreciate everybody's willingness to be able to schedule that far in advance.

Only thing left to note, there is the appendix, follow-ups from the August meeting, answers some

questions, I also noted that the annual report is back there, and then I believe we reviewed this

before, has a list of contracts we are going to decide on during 2026.

No action, just wanted to make sure I note that for the commission.

Before I close, any other questions, comments or concerns, hearing none, I would entertain a motion to adjourn.

>> So moved.

>> CHAIR PROFFITT: A motion from Commissioner Dechant.

This should be the easy one, second from Commissioner Cain.

All in favor, say "aye."

[ chorus of ayes ]

any opposed.

We are adjourned, thank you.