



**MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
May 23, 2022**

The State Employee Benefits Committee (the “Committee”) met at 2:00 p.m. on May 23, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, participants had the option to attend this meeting virtually via WebEx in addition to the option to attend in person.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget (“OMB”), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources (“DHR”), SEBC Co-Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer (“OST”)
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance (“DOI”)
Controller General Ruth Ann Jones, Office of the Controller General (“OCG”)
Secretary Molly Magarik, Department of Health & Social Services (“DHSS”)
Mr. Jeff Taschner, Executive Director, Delaware State Education Association (“DSEA”)
Mr. Keith Warren, Chief of Staff, Office of the Lt. Governor (Designee OBO Lt. Governor Bethany Hall-Long)
Ms. Ashley Tucker, Deputy State Court Administrator, Administrative Office of the Courts (Designee OBO The Honorable Chief Justice Collins Seitz, Delaware Supreme Court)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office (“SBO”), DHR	Ms. Julie Greenwood, University of Delaware
Deputy Director Leighann Hinkle, SBO, DHR	Ms. Jeanette Hammon, Sr. Fiscal and Policy Analyst, Office of Management & Budget (“OMB”)
Ms. Adria Martinelli, Deputy Attorney General, Department of Justice, SEBC Legal Counsel	Ms. Sandy Hart, IBM Watson Health
Mr. Chris Giovannello, Willis Towers Watson (“WTW”)	Ms. Charlene Hrivnak, CVS Health
Ms. Jaclyn Iglesias, WTW	Ms. Heather Johnson, Controller, DHR
Mr. Brian Stitzel, WTW	Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance (“DOF”)
Ms. Rebecca Warnken, WTW	Mr. Adam Knox, Highmark Delaware
Ms. Gabby Costagliola, WTW	Mr. Dan Madrid, Chief Operating Officer, OST
Ms. Joanna Adams, Pension Administrator, Office of Pensions (“OPen”)	Ms. Lisa Mantegna, Highmark Delaware
Ms. Judy Anderson, Executive Director, DSEA	Mr. Walt Mateja, IBM Watson Health
Ms. Wendy Beck, Highmark Delaware	Ms. Brooke Nedza, Aetna
Ms. Christina Bryan, Delaware Healthcare Association	Mr. Anthony Onugu, United Medical
Mr. Randall Bryniarski, CVS Health	Mr. Terrane Pringle, Aon
Ms. Rebecca Byrd, ByrdGomes	Ms. Paula Roy, Roy Associates
Ms. Michelle Carpenter, PHRST	Ms. Judi Schock, Deputy Principal Assistant, OMB
Ms. Jeanie Carson, Highmark Delaware	Mr. Charles Simons, Highmark Delaware
Ms. Julie Caynor, Aetna	Mr. Robert Scoglietti, Deputy Controller General, Office of the Controller General (“OCG”)
Dr. Jessilene Corbett, Deputy Secretary, DHR	Mr. Ted George, Pension Spokesperson (Public Comment)
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS	Ms. Carole Mick, SBO, DHR – Recorder
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR	

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CALLED TO ORDER – DIRECTOR FAITH RENTZ, DHR, SBO

Director Rentz called the meeting to order at 2:04 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO

A MOTION was made by Treasurer Davis and seconded by Secretary Magarik to approve the minutes from the April 25, 2022, meeting of the State Employee Benefits Committee.

MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO

Medicare Advantage (MA) Implementation

Ms. Rentz shared that an introductory letter from SBO and the Office of Pensions will be mailed to all Medicare eligible pensioners and spouses on June 1st, 2022. That mailing will include a specific branding and messaging that is planned to be included with the intention of this branding to help pensioners identify the important information that they will be receiving related to the MA implementation. A new Highmark Medicare Advantage webpage on SBO's website is being moved into production on May 26th. The Pension Office will link from its home page to this page by June 1st, and in coordination with the first introductory mailing on June 1st. A Highmark comparison chart (Medicfill vs MA) and FAQs document will be included in the mailing and posted to the SBO MA webpage. The webpage will also include a timeline of key communications and dates for in-person information sessions that are scheduled for each county for the month of August. Director Rentz also confirmed that open enrollment for State of Delaware Medicare pensioners and spouses will be from October 3rd through October 24th. SBO will be sending a memo to the communications sections within the General Assembly (delivered June 1st) to notify legislators about the upcoming mailing to Medicare pensioners. A mailing is scheduled for mid-June and will be sent by Highmark to all currently enrolled Special Medicfill with prescription members. The Pension Office will be sending a mailing to all other benefit eligible Medicare State of Delaware pensioners and spouses.

Open Enrollment Update

Open enrollment closed on May 18th and open enrollment statewide participation is down slightly (from 84% in 2021 to 83.4% in 2022). Secretary DeMatteis will be sending out participation by agency to all agency leadership this week. Employees received a notice today from the SBO notifying them that open enrollment is now closed and reminding them to review their benefit elections and outreach to their HR Office by Friday, May 27th if there are any errors.

Other Updates

No specific legislative updates at this time, though some pending and recent legislation will be reviewed as part of agenda item #6.

The combined Subcommittee members met on May 19th to continue to review additional condition-specific program options for consideration and a potential recommendation to the SEBC later this summer.

The Subcommittees will not meet in June, but the full SEBC will meet on June 27.

Director Cade joined the meeting in person.

REQUEST FOR PROPOSAL FOR CONSULTING AND ACTUARIAL SERVICES FOR THE STATE OF DELAWARE'S GROUP HEALTH INSURANCE PROGRAM – DIRECTOR FAITH RENTZ, DHR, SBO

The Proposal Review Committee (PRC) recently met regarding the RFP for Consulting and Actuarial Services for the State's GHIP. This contract award is for an effective date of July 1st. In November 2021 through January 2022, the RFP scope of work, evaluation criteria, and minimum requirements were developed by the SBO. In January 2022, the RFP was released, and in March, the SBO received three bids – Aon, Conner Strong Buckelew, and Willis Towers Watson, the incumbent. There were two additional companies that indicated an intent-to-bid – Milliman, who withdrew, and Teus Health, who wished to be considered as a subcontractor. In March through April 2022, the SBO and members of the PRC reviewed the proposals, conducted the preliminary consensus scores and decided which bidders would be invited to interview. Aon and Willis Towers Watson were invited to appear in person to present their qualifications and overall capabilities. On May 9, 2022, the PRC conducted interviews with the two invited bidders, addressing specific questions about how they can best serve the needs and expectations of the SEBC. Following the meeting, PRC members were asked to finalize their scoresheets in accordance with the RFP requirements. On May 16, 2022, the PRC reconvened via webinar to review and discuss the results of final consensus scores. Willis Towers Watson ranked first with a score of 84.88; Aon ranked second with a score of 77.44 and Connor Strong Buckelew's scores were revised for a score of 67.94.

As such, the PRC recommends pursuant to the RFP for Consulting and Actuarial Services for the State GHIP, a contract award to Willis Towers Watson for an initial three-year term effective July 1, 2022 through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to a finalized contract which shall include performance guarantees.

No questions or comments from Committee members were raised. Director Rentz asked Director Cade, who confirmed, that the intention is to wait until after public comment for the Committee to take a vote on this item.

FINANCIALS – MR. CHRIS GIOVANNELLO AND MR. BRIAN STITZEL, WTW

April Fund Equity Report

Under Other Revenues, there was a coverage gap discount payment that was received along with a payment from the ESI Safeguard Rx program (\$52,000) and the Aetna CareVio Year Three reconciliation payment of \$20,000. Claims were about \$62M relative to \$92M budgeted which was driven by the latest COVID reimbursement payment for testing and treatment costs from the 2021 calendar year (CARES Act funding). We were previously estimating a reimbursement payment of about \$24 million that would occur in FY23, and this payment was about \$29 million which occurred in April. The total payment of \$29 million is consistent with prior payments as an offset to claims and factoring in the reimbursement payment in April, resulting in a \$28.4 million surplus for the month of April. All in for April, \$14 million in net income compared to \$13.6 million of an expected loss, driven by that reimbursement payment. The fund equity balance is reflecting \$162 million through April.

Quarterly Financial Reporting

This report looks at year to date experience through quarter three (March) FY22, compared to the same period for FY21. For the first nine months of the fiscal year, gross claims, medical and pharmacy costs have increased about 3% overall. The total program cost is flat when comparing it to FY21 (decreased 0.1%) and this is mostly due to favorable pharmacy experience by an increase in other pharmacy revenues (such as rebate payments, EGWP revenues, etc.) offsetting gross claim costs; in FY22, there will be an extra rebate payment with the transition from ESI to CVS (rebate payments are now paid one quarter sooner than they previously were). Premium contributions saw a slight decrease when compared to FY21 and on a per employee per year (PEPY)/per member per year (PMPY) basis.

Next table compares actual FY22 program costs to the FY22 original budget. Compared to the last quarterly financial report (Q2 FY22), medical claims are down slightly in this quarter (about \$15 million from the March Fund Equity report YTD that's being excluded from this quarterly financial report). Relative to FY22 budget, FY22

actual experience through Q3 was favorable by 5.1%; factoring in the \$15 million from the March Fund Equity report, actuals would be about 3% favorable to budget.

The last table shows FY22 experience broken out by Aetna vs. Highmark and by participant status. Medicare retirees have an 81% loss ratio for FY22. When we were first discussing moving this population to a group MA plan, there's about a \$23 million delta between the total cost for Medicare Retirees and the budgeted premium contributions. So, by carving out the Medicare retirees, this creates a \$23 million in surplus that needs to be made up for by the remaining participants which would now be the Actives and non-Medicare retirees. Looking at those two groups, Actives have a loss ratio of 105% and non-Medicare retirees have a loss ratio of 134%. Non-Medicare retirees cost more than Actives based on the demographic profile, but both populations have the same premium rates, which is something to consider as we think about the future state of the plan and premium contribution development. We do have some rate increases for future consideration and we have lost that Medicare subsidy.

There were no questions from Committee members about the quarterly financial report.

FY23 Projections and Utilization Update

When we met in February, our long-term projection was based on the latest claim experience available through FY22 Q2; the forecast \$62.7 million deficit by the end of FY23 which would grow to \$219 million by the end of FY24. During the February SEBC meeting, the Committee voted on the following measures, which we have reflected in the latest long-term projection: move Medicfill population to Group MA plan (medical only and administered by Highmark) and continue offering EGWP drug coverage through SilverScript, implement 8.67% premium rate increase (effective 7/1/22 for actives and non-Medicare retirees, and on 1/1/23 for Medicare retirees with EGWP drug coverage), and adopt the CVS Drug Savings Review Program (effective 7/1/2022 for non-Medicare Aetna and Highmark members). During the April SEBC meeting, the Committee voted on the following additional measures: eliminate option for Medicare participants to enroll in medical coverage without prescription drug coverage (effective 1/1/23), and adopt the CVS Transform Diabetes Care for Aetna members and continue the Livongo diabetes care management program for Highmark members (both effective 7/1/22).

Mr. Giovannello walked through the projected surpluses and deficits for FY22, FY23 and FY24. For FY22, we were previously starting off with a \$30.2 million projected surplus. Due to the \$29 million COVID reimbursement payment hitting the Fund in April and not in FY23 our FY22 surplus has increased by \$29 million. Under Other Revenues, the EGWP rebate payments have been running higher than forecast in FY22, which is the \$2.9 million reflected in the chart. We are going from a \$30.2 million surplus to a \$61.9 million surplus for the end of this fiscal year. For FY23, we were starting with a \$62.7 million deficit, which was the basis of the 8.67% rate action (adds \$62.9 million in revenue to the Fund); this rate action is now incorporated into our long-term projection and offsets the projected deficit in FY23. There's an additional \$5 million in surplus because the amount of the COVID reimbursement payment was \$29 million and we were previously forecasting \$24 million. Claims experience was relatively stable, and the updated other revenues is due to new participants in drug coverage, which will lead to some additional rebate payments for the EGWP. An \$8.8 million surplus is expected by the end of FY23, due to the COVID reimbursement payment and favorability in other revenue items. For FY24, our prior forecast was \$219.3 million deficit. The impact of the 8.67% rate action compounds each year, so we now have \$129.4 million in additional revenue, over FY23 and into FY24 and reducing the FY24 deficit. We are projecting a \$79.1 million deficit for FY24, which we'll discuss what that means in terms of a potential rate action.

Director Cade asked if the FY23 numbers factor in the rate increase that the SEBC voted on earlier this year. Mr. Giovannello responded that is correct, that is shown in the first line item (\$62.9 million in FY23).

On the next slide, we're reflecting previously mentioned future long-term projections for FY22, FY23, and FY24. If you just look at the experience in FY24 relative to FY23, you can see some favorable trends. Overall, we're only

showing a 2.5% increase in Operating Expenses on a per member per year basis. You can see significant growth in the Other Revenues, going from about \$188 million to \$223 million due to the new CVS Health contract, where we expect rebate improvements and contractual savings. The line item highlighted in blue, where you'll see the 8.67% rate action each year, starting in FY23. Premium contributions are going from \$804 million to \$767 million, due to moving the Medicare population into a group MA plan with a \$0 medical only premium, so we're now losing that subsidy from that population which will decrease contributions. The experience is favorable, but there are some other factors at play which are contributing to the FY24 deficit. This reflects all items voted on by the SEBC as of the April 25 meeting, but we're not reflecting any potential impact from pending legislation or legislation with an unknown outcome on the GHIP, such as SS1 for SB120 which could have an impact in FY23 and beyond. As we get more information on the cost impact of outstanding legislation, we'll incorporate it into our long-term projections, but this is something to keep in mind, recognizing that the \$79.1 million deficit does not include the impact of that legislation.

Mr. Taschner asked if both expenses and revenues for FY23 have been adjusted for the loss of the Medicare retiree revenue in the same way. Mr. Giovannello responded that is correct. The 5.4% change in operating expenses per member is elevated because FY22 has \$29 million coming out of operating expenses. The 5.4% would be lower if not for the \$29 million payment in FY22.

Slide 6 captures pending legislation that is not included in our long-term projections at this point, but these could potentially have a cost impact in the future, which we will build into our projections once further details are known about the cost impact on the GHIP.

Mr. Giovannello reviewed potential premium rate increase scenarios considering the projected FY24 deficit. The \$79.1 million projected FY24 deficit is caused by three main things: healthcare trend, lost Medicfill subsidy, and the GHIP surplus being fully depleted by the end of FY23. Favorable projected experience for FY23, including operating expenses increasing by 2.5% over FY23, other revenues that are projected to increase \$34.7 million higher than FY23 and offset by a \$36.7 million reduction in premium revenue. This does require additional active and pre-65 retiree contributions to make up for the projected deficit, to be offset by any additional program changes that would lower the deficit as well. A 10% rate increase effective 7/1/2023 is required to solve for the \$79.1 million projected FY24 deficit. There is available surplus to offset premium increases by end of FY23 results in larger rate actions needed to solve for future deficits. Smoothing the rate increase over three years to solve for FY26 deficit requires an 8% annual rate increases per year in FY24, FY25, and FY26. The potential impact of future Delaware legislative activity may further increase the projected deficit, and any additional increases in health care trend beyond the 5.5% medical and 8% pharmacy trend assumptions may have a similar result.

Commissioner Navarro asked, related to pending legislation, whether the \$1.8 million price tag associated with HB 219 is an additional cost or savings. Ms. Rentz responded that it is an additional cost to the GHIP, due to the recontacting requirements of HB 219 in play between CVS and the retail pharmacies to reimburse at a higher rate. The estimate is based on actual repricing of GHIP claims for the period of 10/1/2021 – 04/01/2022, which has been annualized.

FY23/FY24 Cost Avoidance Opportunities

Mr. Stitzel provided an overview of potential cost avoidance opportunities that are the least disruptive to GHIP. One tactic is to move the non-Medicare retirees to the ACA pre-65 retiree marketplace and provide them with an HRA that can be used to offset participants' cost of purchasing insurance on the marketplace. With this option, members will have more choice of plan options, potentially lower premium costs, options for low-income subsidies, and reduced OPEB liability (which is a goal of the Retirement Benefits Study Committee).

The option to expanding the GHIP's COE strategy by mandating bariatric surgery through SurgeryPlus and other surgical procedures could reduce cost by steering members to high quality providers that produce better health

outcomes, which can result in reduced long-term costs. Potential implications could include some provider disruption and may move care out-of-state; estimated savings for FY24 could be in excess of \$10 million but requires further analysis. Another consideration is to implement a CDHP/HSA plan to drive additional health care consumerism and may also support employee attraction/retention efforts. With a CDHP/HSA plan, there is potential for member disruption due to the requirement for members to meet a higher deductible prior to the plan sharing in the cost of services (though potential savings for FY24 could range from \$2-\$10 million). Other considerations include value-based contracting arrangements, implementation of PrudentRx, and implementation of a musculoskeletal (MSK) solution.

Slides 9-10 reflect illustrative premiums for FY24 based on two rate increase scenarios (8% and 10%).

GHIP Utilization Updates

Mr. Giovannello reviewed utilization updates for key areas of spend based on incurred reporting from IBM Watson Health through December of 2021 and relative to 2019 and 2020 utilization. The key question from this analysis is whether the comparison of 2019 to 2021 utilization can offer any meaningful insights into trends, along with what these trends could look like in the future.

Inpatient hospital admissions per 1,000 were stable from 2020 to 2021, but the allowed per admission increase of 4.6% was driven by increased severity and an average length of stay increasing 5.8%. Inpatient facility payments increased by 7.8% (\$11.8 million) from 2020 to 2021, and 7.3% (\$13.8M) over 2019. Inpatient surgical stays decreased 7.7% and per-employee-per-month (PEPM) cost has decreased 11.5%. Inpatient medical utilization increased by 10% and drove to a 19.7% increase in PEPM cost. The PEPM payments for maternity increased 40.3% over 2020 (\$8.6 million). Outpatient facility claims rose \$24.4M from 2020 to 2021, reflecting an increase of 15.2% PEPM; for 2021, PEPM cost for outpatient facility charges was only 4.3% higher than 2019. In 2021, outpatient surgeries surpassed the 2019 utilization rates, while ER, specialty drugs, and diagnostic services still lag behind utilization levels from 2019. This indicates a potential for pent-up demand to drive additional utilization in 2022 and beyond. Mr. Giovannello discussed the utilization of other services where physician outpatient, radiology outpatient and physician inpatient categories reflected decreased PEPM cost compared to 2019, while other professional services had modest gains. Mental health and substance abuse has steadily increased since 2019, with increase of 13.1% in 2020 and 30.7% in 2021. Outpatient laboratory PEPM increased rapidly in 2021, up 27.4% over 2020, triggered by increases in utilization and unit cost.

FEDERAL/STATE POLICY IMPACTING THE GHIP – MS. JACLYN IGLESIAS, WTW

Ms. Iglesias provided an overview of current and upcoming requirements for the GHIP stemming from recent and pending federal and state legislation.

At the federal level, the Transparency in Coverage (TiC) Final Rule was enacted by President Trump's executive order 13877 ("Improving Price and Quality Transparency") and was derived from the statutory requirement in the Affordable Care Act (specifically section 1331 of the ACA which is incorporated into Section 2715A of the Public Health Service Act). It will impact employer-plan sponsors of group health plans by expanding information that certain group health plans must disclose to participants, beneficiaries and enrollees in health plans. This will be a phased-in approach over multiple years starting in 2022. The Transparency Final Rule (TFR) issued last November includes two primary requirements: disclosure of negotiated rates and provision of Advanced Explanation of Benefits, effective starting in 2023 with full implementation in 2024.

The Consolidated Appropriations Act (CAA) was passed in 2020 and is broken out into two titles: Title I of this Act is referred to as the "No Surprises Act" which ends some surprise medical billing practices for plan years starting on or after January 1, 2022. Requirements of this Act will be taking effect for the GHIP starting on July 1, 2022 for the State's FY23 plan year. Title 2 outlines several additional rules around transparency in coverage, some of which are already in place for the GHIP.

The Transparency Final Rule requires plans to make available to the public three separate machine-readable files that include detailed negotiated prices related to: in-network information, out-of-network information, and prescription drug information. The files must be updated monthly, posted on the insurers or plan's website, and provided free of charge. These files should be made available by July 1st, 2022 except for the prescription drug information file, whose effective date has yet to be determined. The SBO has been working with both medical carriers, CVS Health and SurgeryPlus to understand each vendor's capabilities to provide these machine-readable files, the timing of when those will be available, and coordinating how those will be made available to GHIP participants. Aetna, Highmark and SurgeryPlus are preparing to meet the July 1 effective date.

Slide 5 reflects the provisions of the Consolidated Appropriations Act (CAA) that are either currently in effect or are about to take effect for the GHIP. The SBO has been working with the medical carriers to ensure compliance with each of the provisions. Slide 6 reflects other requirements of the CAA and TiC that will become effective in either 2022 or 2023.

Ms. Iglesias provided a brief recap of the COVID-19 benefit enhancements under the GHIP that are set to expire following the end date of the U.S. DHHS emergency declaration ("Public Health Emergency") and discussed the implications for extending the end date to match the emergency declaration with the later end date ("National Emergency Declaration. During the April 25, 2022, SEBC meeting, the Committee requested information on how other states are handling COVID-related benefit enhancements tied to the Public Health Emergency. So far, outreach to other states and large employers about this issue has indicated that those plan sponsors who are still maintaining COVID-related benefit enhancements including waived copays and deductibles for COVID-19 testing and treatment have not communicated a specific deadline to plan participants. WTW is continuing to conduct outreach and will provide an additional update to the SEBC in June. Further discussion with the SEBC will take place at the June 2022 meeting to review and confirm the timing for any future extensions of the COVID-19 benefit enhancements currently tied to the Public Health Emergency which ends on July 15, 2022.

Ms. Iglesias concluded this segment of the presentation with an overview of other pending and recently enacted state legislation that could affect the GHIP, which are described on slides 9-11 of the meeting material.

Secretary DeMatteis joined the meeting during this final segment.

No questions or comments were provided by Committee members.

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT

Ted George, representing pensioners other than the State Police, made public comment. Mr. George noted that there have been several complaints around the recently approved 3-year dental contracts with Dominion National and Delta Dental. Concerns included the SEBC's decision to extend the dental carriers' contracts by an additional year last year without sufficient prior notice to plan participants, limitations around plan participants' ability to select a primary dental provider under the DHMO, and the current plans' willingness to cover certain services without additional member out-of-pocket cost. Mr. George inquired about whether other dental carriers were considered beyond the two incumbents.

APPROVAL OF REQUEST FOR PROPOSAL FOR CONSULTING AND ACTUARIAL SERVICES FOR THE STATE OF DELAWARE'S GROUP HEALTH INSURANCE PROGRAM – DIRECTOR CADE

To the award of a contract pursuant to the Request for Proposal for Consulting and Actuarial Services for the State of Delaware Group Health Insurance Plan, a contract award to Willis Towers Watson for an initial three-year

term effective July 1, 2022 through June 30, 2025, with two optional one-year period extensions. Such award shall be subject to a finalized contract which shall include performance guarantees.

A MOTION was made by Mr. Taschner and seconded by Secretary Magarik.

MOTION FOR DISCUSSION

No discussion.

MOTION ADOPTED UNANIMOUSLY

LEVEL III DISABILITY APPEAL

Prior to the motion for moving into Executive Session, Director Rentz indicated, for members of the public who are participating in today's meeting, that when the SEBC adjourns from Executive Session and returns to Public Session, that there will be no further business discussed by the Committee, and they will only be discussing a Level III Disability appeal in today's Executive Session.

A MOTION was made by Secretary DeMatteis and seconded by Mr. Taschner to adjourn the Public Session at 3:34 p.m.

MOTION ADOPTED UNANIMOUSLY

ADJOURNMENT

After moving back into Public Session and with no further business, A MOTION was made by Mr. Taschner and seconded by Secretary DeMatteis to adjourn the Public Session at 3:53 p.m.

MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

Carole Mick, Administrative Specialist, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees