

**State Employee Benefits Committee  
Friday, June 10, 2016 at 1:30 p.m.  
Tatnall Building, Room 112  
Dover, Delaware**

The State Employee Benefits Committee met on June 10, 2016, at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

**Committee Members:**

Brian Maxwell, Director, Office of Management and Budget  
Tom Cook, Secretary of Finance  
Geoff Klopp, President, Correctional Officers Association of Delaware  
Rita Landgraf, Secretary of Health and Social Services  
Evelyn Nestlerode, Designee of Chief Justice  
Kimberly Reinagel-Nietubicz, Designee of Controller General  
Ken Simpler, State Treasurer  
Rhonda West, Designee of Insurance Commissioner

**Guests:**

Brenda Lakeman, Director, SBO  
Faith Rentz, Deputy Director, SBO  
Lisa Porter, SBO  
Lisa Carmean, City of Milford  
David Craik, Pensions  
Cindy Diaz, PHRST  
Jill Fredel, DHSS  
Judy Grant, HMS  
Pat Griffin, AOC  
Kim Hawkins, City of Dover  
Leighann Hinkle, SBO  
Chris Hudson, Univ of DE  
Andrew Kerber, DOJ  
Marie Klinkwood

**Guests (cont'd):**

David Leiter, DHSS  
Omar Masood, OST  
Laura Nard, DE Health Care Commission  
Kathy Nerlinger, Univ of DE  
Casey Oravez, OMB  
Lori Peddicord, City of Dover  
Karol Powers-Case, DRSPA  
Mark Purpura, Equality Delaware, Inc.  
Frank Pyle, DOI  
Leslie Ramsey, SBO  
Paula Roy, Roy Associates/DCSN  
Shari Sack, Aflac  
Aaron Schrader, SBO  
Wayne Smith, DE Healthcare Assoc.  
Mark Thompson, Medical Society of DE  
  
Katherine Impellizzeri, Aetna  
Jennifer Mossman, Highmark  
Howard Atkinson, Segal Group  
Angela Hua, Truven Consulting  
Walt Mateja, Truven Consulting  
Kevin Fyock, Willis Towers Watson  
James DiGuiseppe, Willis Towers Watson

**Introductions/Sign In**

Director Maxwell called the meeting to order at 1:30 p.m. Introductions were made. Anyone who had public comment was invited to sign up to provide comment at the end of the meeting.

**Director's Report – Brenda Lakeman**

Open enrollment closed successfully with over 10,000 State employee's accessing e-Benefits to either confirm or make changes to their benefits. This is a passive enrollment and action is not required. There are 2,670 SOD employees that cover a spouse who have not yet completed their Spousal Coordination Benefits form. A list from PHRST of these employees has been distributed to the agencies and school districts to contact those employees to request completion of the form. In the next two weeks, SBO will send a letter out to employees informing them of sanctions if the form is not completed and spouse's claims will be covered at only 20%.

Senate Bill 238 is in the Legislature and would allow the DE Health Information Network to establish a Delaware Health Care Claims Database to include information from the State Group Health Plan (GHIP), Medicaid Plan, qualified health care plans through the exchange and other health insurers and providers that were interesting in sending in their data. This bill passed the Senate June 9<sup>th</sup> and will be going to the House for vote. We will keep the SEBC informed as it moves through the legislative process.

## Financial Reporting

### Fund Equity – May 2016 – handout – Casey Oravez

- Ending balance as of May 31<sup>st</sup> - \$40.3M
- Projected Fund Equity balance through June will be \$31.2M and will likely go down due to 5 weeks of claims payments in June
- The projected deficit in the claim liability is currently at \$13.7M and with no minimum reserve.

### FY16 Qtr 3 Financial Reporting – handout – Howard Atkinson

The key findings for Q3 FY16 YTD were shared:

#### Overall

- \$549.3M in revenue; an increase of 16.7% over same quarters in FY2015
- Claims and expenses are at \$526.7M; a decrease of 0.7% from same quarters in FY2015
- During this nine-month period, there was an average of 67,848 actives and retirees covered under the plans, an increase of 1.6% from the prior year
- There was an average of 122,470 members covered under the plans; an increase of 1.2% from the prior year

#### Medical

- Medical claims were \$370.9M, a 0.2% increase over prior period
- On a per member basis, the average annualized medical spend was \$4,247, a decrease of 0.61% from prior year
- Highmark PPO and Active employees had the most covered lives (46,115) and had an annualized \$4,903 per member cost, a decrease of 1.49% from prior year
- Combining Actives and Pre-Medicare Retirees, Highmark Basic and both Aetna Plans (CDH, HMO) had 10% or larger increase in average cost

#### Prescription

- Prescription Drug claims were \$179.4M. After accounting for administrative costs, less rebates and EGWP savings, total prescription drug costs were \$128.7 million
- Estimated Prescription Drug Rebates of \$29.9 million and EGWP Revenue of \$22.3 million offset a total of \$52.2 million, or 29.1% of prescription drug costs.
- On a per member basis, the average annualized prescription drug spend was \$1,401, a decrease of 17% from the prior year. This decrease could be due to the program put in place for compound medicine, as well as drug inflation lower than expected.
- PPO Non-Medicare retirees had the highest annualized cost per member at \$2,672.

### Disability Insurance Program Rules and Regulations- handout – Brenda Lakeman

The handout shows the proposed revisions effective July 1, 2016 with new language shown in purple. Most of these changes are simply a clarification or changes in title. Ms. Lakeman reviewed the handout. There are no real changes in the way the program is administered.

### State Innovation Model (SIM)-Purpose and Initiatives – handout – Secretary Rita Landgraf

Secretary Landgraf presented an overview of this model which included: The case for change, Strategy and goals, Current progress and the role of SEBC.

- **Employers** are facing increasing costs, an unhealthy workforce, and complex decisions
- **Providers** lack time and resources to proactively coordinate care
- Health care is confusing for **Patients**, and premiums are rising

Data provided by the source of United Health Foundation's America's Health Rankings/Spotlight: Impact of Unhealthy Behaviors (2014 Data) showed 5 Unhealthy Behaviors: Smoking, Physical Inactivity, Excessive drinking, Obesity, Insufficient sleep. Delaware ranked 24.7% where the U.S. ranked 28.1% for Zero Unhealthy Behaviors. With three or more unhealthy behaviors, Delaware ranked 13.6% where the U.S. ranked 12%.

Aspirations for Triple Aim: Become 1 of the 5 healthiest states in the U.S., Achieve top 10% performance for quality/patient experience, Bring health care spending growth more closely in line with growth of economy  
PLUS ONE: Achieve higher provider experience

Goals to Achieve through Plan include:

- Payer participation: across commercial & government
- Better value: through better care at lower cost, up to \$1 billion in value over next several years
- Sustainability: reinvest half of gains in providers
- Affordability: half of savings captured by consumers, employers, plan sponsors

Vision

- All Delawareans will have a primary care provider, and it will be simple for them to access care when they need it
- Providers will be rewarded for innovative and efficient approaches to delivering quality care.
- When people need to go to the ER, they will not need to repeat their medical history and prescription information
- Providers will have the time and resources to reach out after a hospital discharge to make sure the patient receives a follow-up appointment with his PCP
- When a mother needs help caring for her child with asthma, she will know where to turn.
- Providers will work more closely together so that patients will feel as though the individuals caring for them, including behavioral health providers, are part of a team
- Employers will be able to continue providing health insurance to their employees

The Delaware Center for Health Innovation: Public-private Governance Model was shown.

The broad Stakeholder Group remains involved with Governor Markell and every health care agency in Delaware, every large payer, consumer advocacy groups, business community, extensive provider participation, numerous public officials and agencies and large educational institutions.

Delaware's Strategy – Patient at center of everything Delaware does

- Transformation of primary care through PCMHs and ACOs
- Innovative two-year learning and development program with common curriculum on team-based, integrated care
- Scorecard, tools, data, and resources to support neighborhoods
- Integration of community-based health initiatives with delivery system focused on priority health needs
- Medicaid MCO, state employees, and QHP standards to drive adoption
- Care coordination funding in addition to outcomes-based payments
- Multi-payer adoption of value-based payment on statewide basis
- First in the country multi-payer Common Scorecard for primary care
- Support for primary care practice transformation and care coordination

Progress to date

2011 – 2014 Initial pilots and planning

- Adopted new models through individual physicians, societies, hospitals (e.g., PCMH, ACOs)
- Shaped Delaware State Health Innovation Plan through more than 50 workgroups and public meetings
- Formed Delaware Center for Health Innovation as public-private partnership

2015 Design for scale

- Designed core program elements and launched:
- 21 provider sites live with Common Scorecard
- 75% quality measures in payers' outcome based models reflected in Common Scorecard

- 4 practice transformation vendors selected to support providers
- Leveraged Medicaid MCO RFP

Secretary Landgraf shared where we are today, the changing landscape, examples of APCD use cases in other states, access to claims data with the potential data flow and operations, and what is a Healthy Neighborhood (three of which are scheduled to launch in 2016). As Nemours is our children's hospital, they will be supporting this work throughout the State as well as a federally qualified health center. Finally the role of SEBC is to leverage the RFP process, encourage health consumerism and continue engagement in DCHI. Director Maxwell thanked the Secretary for this very informative presentation and opened it up for questions while also asking if OMB could communicate with the Secretary's staff and learn how they leveraged the Medicaid RFP process to garner more value and make continued progress in the movement toward pay for performance models.

Treasurer Simpler asked thinking of this RFP process, how large a buyer are we when it comes to Delaware's health care market and how big is our buying power. Ms. Landgraf responded to refer to it as the State's buying power. Medicaid represents 230,000 lives and the employee benefits program (GHIP) represents 122,000. When all these lives are put together, that gives you the perspective of the level of the buying power that the State does encompass.

Treasurer Simpler asked what are the ways we are going to steer and coordinate with 100,000 non-Medicare lives in our program, how do we coordinate the efforts of the GHIP with the overall efforts of the Innovation model. Ms. Landgraf commented it starts with the RFP process and how we take this model and incorporate it as part of the RFP as done with the Medicaid RFP laying out this is the expectation. This approach actually had more insurers coming to the table than the State has ever had before for the Medicaid RFP having five come to the table initially. The goal was to remain as transparent as possible and move away from the fee for service model of payment and into a pay for value which would be looking at the ability to afford a new level of health innovation and also a level of accountability with the goal of looking closer on the outcomes to promote health.

Treasurer Simpler commented we are making fairly micro level decisions around how to save a few million dollars without really a collective consensus on what is the health care problem at large and how do we fit our decision making for approximately 100,000 thousand non-Medicare lives into a strategy in a State with a population of 930,000. The SEBC has contracted with a consultant, Willis Towers Watson (WTW) to help us think strategically and Delaware Center for Health Innovation (DCHI) has its own consultant, McKinsey. Secretary Landgraf stated the benefit of having Ms. Lakeman on the DCHI Board and as is Secretary Landgraf, is partnering and ensuring we are integrating with these programs along with Medicaid and Medicare through CMS.

Treasurer Simpler stated that DCHI has been at work since 2011, and asked if we are bringing WTW on board with the assumption they will embrace the conclusions that have already been reached by the DCHI or are they being engaged to think a new strategy for this committee outside of the framework that DCHI has already framed. Secretary Landgraf commented her hope that WTW and the SEBC will be working off the principles that DCHI has embraced. Ms. Lakeman stated it would be unfair to ask WTW to not think independently but when you already have a strategy in place and that has been embraced by the payors and the providers and a lot of work done, you would not want to take a different path. There may, however, be other things that would work for our population that would not work for the whole population.

Secretary Landgraf commented to think of the work being done to promote the Delaware Health Care Claims Database and this is additional information in the aggregate and could be broken down for this population specifically.

Mr. Klopp added how the SEBC continues to talk about great ideas but with the presentations made a few months back by Aetna and Highmark, telling us that we were being geographically monopolized by our hospitals, it is imperative that we continue to work on the consumer side and continue to focus on what is being charged by the hospitals. Ms. Lakeman agreed and added the hospitals are moving to different payment models.

### **Introduction of New SEBC Consultants, Willis Towers Watson – Brenda Lakeman**

Ms. Lakeman introduced Kevin Fyock and James DiGuiseppe from Willis Towers Watson (WTW) who will be the lead benefit consultants for primary consulting services as well as development and support related to the Health RFP. Ms. Lakeman addressed some of the Treasurer's questions in that have already had several meetings internally with the team but also had a three hour meeting with one of the lead consultants from McKinsey and the meeting was very informative to help them start thinking about the Health RFP and incorporating the DCHI work. There will be three other consultants on contract for other SEBC work as needed. SBO will ask for proposals from all the consultants and the committee will decide the most appropriate firm based on the work being requested and the proposals submitted.

Mr. Fyock, WTW, presented at a high level the scope of services for the Health Insurance RFP. The benchmark timeline was presented and it was explained that WTW has been charged with formulating a multi-year strategy with the SEBC working in conjunction with the current DCHI strategies that have been in play since 2011. In addition, WTW will identify additional opportunities to help drive consumerism and further streamline the employee benefits offering. The Health Insurance RFP is intended to be a part of the overall GHIP strategy. The second piece of their core services would be Plan and Vendor Management. This would be broken up into three further areas:

1. Financial Management – working on developing an annual benefits budget, including rates and contributions for the members and preparation of quarterly detailed financial reporting similar to the information that Segal previously provided
2. Vendor Renewals – working with the State's different vendors to review renewals, negotiate those renewals and ultimately ensure they are contracted appropriately
3. Compliance – related to the employee benefit plan to ensure that we are complying around the area of COBRA, HIPAA, ACA, etc. Finally to provide guidance and updates on emerging legislation both at the State and Federal levels.

Treasurer Simpler asked if the final contract has a Scope of Services (SOS) that is different than what is here. Ms. Lakeman responded that the scope is consistent but much more detailed. A copy will be provided to the Treasurer.

Mr. Fyock referred to the Health Insurance RFP Timeline with the key dates as shown in the handout. The first draft of the RFP with Executive Summary will be provided to the SEBC for comment on June 20, 2016. Three different drafts reviews will be performed and ultimately providing the final RFP to the Government Support Services for their posting. The advertisement of the RFP is anticipated for August 15, 2016. Bidders will have about 6 weeks to respond, bringing the response deadline date to September 26, 2016. An analysis of the qualifications and determination of finalists for the SEBC and finalists interviews will be conducted October 31 and November 1, 2016. Contract award recommendation due to the SEBC at the November 14, 2016 meeting. Ms. Rentz added the Proposal Review Committee members have received invitations to the finalist interviews and the invitation will be extended to the SEBC.

Treasurer Simpler inquired to what extent does the RFP express a view about how we are going to solve the broader health care problem. It would be helpful to expand upon our strategy at large. He was interested in knowing whether the RFP limits the SEBC's choices or if the RFP is agnostic about how we solve the broader problem and asked that these questions be addressed at the June 24<sup>th</sup> SEBC meeting. Ms. Lakeman clarified that the RFP will be broad as it is not intended to be so descriptive that if the SEBC wanted to do something different in a year that another bid would be needed. Concepts such as practice transformation and initiatives that support the State Innovation Model and DCHI work will be sought in the bid responses. Secretary Landgraf stated that her agency would share some of their findings relative to the Medicaid RFP process versus the contractual process versus reality. Treasurer Simpler shared that he wanted to see WTW apply some of what he witnessed during their Consultant RFP finalist interview in terms of clear measurable objectives into the Health RFP. Mr. Fyock reassured the Treasurer that those objectives will be integrated into the Health RFP.

**DOI Insurers Bulletin 86 – Transgender Identity Nondiscrimination Act of 2013 – handout – Faith Rentz**

Transgender Identity Nondiscrimination Act of 2013 – amended Delaware Codes relating to hate crimes and discrimination in employment, public works contracting, housing, equal accommodations and the insurance business on the basis of gender identity.

Department of Insurance Domestic/Foreign Insurers Bulletin No. 86 – provided guidance regarding the implementation of the Gender Nondiscrimination Act of 2013:

- Amended Section 2304(22) of the Unfair Trade Practices Act to make it unlawful practice for any insurance company licensed to do business in Delaware to discriminate in any way based on an individual's gender identity.
- Section 2304(13)(b) prohibits unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premiums, policy fees or rates charged for any policy or contract of health insurance.
- Section 1557 of the Affordable Care Act prohibits discrimination on the basis of sex in any health program receiving federal funds or by an entity established under the ACA.

DOI interprets provisions to prohibit the denial, cancellation, termination, limitation, refusal to issue or renew, or restriction of insurance coverage or benefits thereunder because of a person's gender identity or transgender status, or because the person is undergoing gender transition. This includes the availability of health insurance coverage and the provision of health insurance benefits.

Discussion followed related to extending gender reassignment coverage under the GHIP plans. Aetna and Highmark cost estimates are based upon 1 in every 7,000 health plan members (18 years of age and over) obtaining medical necessity for such services. It is not easily determined the extent of services which would be utilized by members and costs could be fairly volatile, ranging from \$25,000 to \$100,000 per transition (medical plan only) which also vary depending on male to female or female to male procedures. Assuming members received the full range of medically necessary services and therapy within a plan year, costs could be as high as \$1.8M. However, due to the nature of the services, it is more realistic that members would incur the full range of services over an extended period of time. SBO estimates a reasonable annual cost to the GHIP to be more in the range of \$900,000.

Coverage will be in accordance with medical necessity when all of the clinical criteria are met. Components of gender reassignment considered to be cosmetic may be excluded from coverage. Aetna clinical criteria is finalized and can be reviewed at [http://www.aetna.com/cpb/medical/data/600\\_699/0615.html](http://www.aetna.com/cpb/medical/data/600_699/0615.html). Highmark expects to have clinical criteria finalized within next 60 days.

Mr. Klopp asked if any inquiries have been made if other states are covering this procedure. Ms. Rentz responded there a number of states implementing this. Mr. Kerber commented that as of September 2015, Federal Health and Human Services put out their proposed regulation, there were eleven states that had their own requirements mandating this coverage and the number may have changed since then. As a self-insured plan, the SEBC is not subject to Title 18 and DOI Commissioner concurred the mandate does not apply to the GHIP. However Aetna and Highmark will be mandated to implement this coverage with their commercial fully insured population and SEBC practice has been not to exempt coverage from our plan that has been mandated to the commercial fully insured. Ms. Lakeman added that the committee could choose to opt out but similar items have always been brought to the committee and adopted.

More dialog continued around this item. Ms. Rentz stated this will be covered under the Delaware Medicaid program and Medicaid is in the process of finalizing their criteria. Treasurer Simpler expressed concern over the decisions being asked of the committee with regards to determining the inclusion and/or exclusion of certain benefits. Secretary Landgraf reiterated Ms. Lakeman's comments that Aetna and Highmark are already adopting the coverage for their fully insured population. Mr. Klopp agreed with the medical necessity provision yet expressed concern for the newness of these types of procedures and the lack of data related to outcomes and mental health impacts on members receiving these services. A vote will be taken after Public Comments. Mr. Kerber clarified that the federal government issued

final regulations on May 17, 2016 and those regulations are very comprehensive. Treasurer Simpler asked if it would be possible to further refine the estimated first year and ongoing costs associated with the coverage and recognized that while not a significant percentage of the population would incur the services, knowing more about the costs would be helpful to the committee in determining the impacts to the GHIP budget.

#### **DelaWELL Health Management Planning – handout – Brenda Lakeman**

A review of the State recent and ongoing initiatives with actionable items was presented.

- Delaware’s General Assembly passed House Concurrent Resolution 81 – Encouraging wise health care consumerism
- Promote wise health care consumerism and utilization of the *Consumerism Resource Link* ([www.ben.omb.delaware.gov/consumerism](http://www.ben.omb.delaware.gov/consumerism))
- Encourage members to:
  - Know their insurance plan
  - Compare costs and choose lower cost health care services
  - Get appropriate level of care
  - Manage chronic diseases
  - Engage in wellness and prevention
- SBO will:
  - Work with leadership (i.e., SEBC, legislatures, state agencies, school districts, charter schools, unions, etc.) to communicate consumerism information to employees and retirees:
    - Provide onsite seminars
    - Attend health and benefit fairs
    - Promote online via website announcements
    - Share info in newsletter articles
    - Promote via social media
  - Strongly encourage members to complete the *Online Consumerism Training Course* (Expected release is July 2016)
    - Members will be able to access the course via the Delaware Learning Center (DLC) or through a separate link for those without access to the DLC
  - Assess impact of efforts by looking at changes in participation and utilization levels
- Next steps –
  - SBO will continue to work with leadership to communicate information
    - Already in the works:
      - August 2016
        - Meet with DSEA leadership and communications staff
        - Present at Smyrna School District’s new employee orientation
        - Speak at the Delaware Association of Educational Office Professionals (DAEOP) annual professional development day
        - Present at Colonial School District’s Transportation Department meeting
      - Working with Innovative Schools to set-up consumerism workshops at charter school professional development days
      - Attending DSEA member benefit fairs in November

#### **Public Comments**

Ms. Paula Roy, DCSN presented a handout on saving money and improving spine care. Statistics were shared on spine care in the U.S., costly back pain overtreatment, drug free alternatives versus opioids and data analysis from a North Carolina study.

Mr. Dave Leiter expressed his concern of the costs for the gender reassignment coverage taking note of the committee’s recent need to make plan changes to reduce costs and how it seemed illogical to consider coverage that would add to the GHIP expenses.

Ms. Karol Powers-Case concurred and shared that members are going long distances to find places that will not cost the State as much and yet the SEBC is being asked to approve something that is not life threatening and appears to be cosmetic. She also shared that she hopes that the committee gathers input from older members as they consider Medicare plan options.

Mr. Mark Purpura, Equality Delaware applauded the SEBC for entertaining the idea of adding transgender inclusive health care under the GHIP plans. He reminded the committee that currently there is an exclusion under the GHIP plans and as per the HHS regulations that became final last month, that exclusion is clearly not permitted. In terms of the clinical standards mentioned, those standards are likely based upon WPATH guidelines which has existed since 1979 and include standards related to mental health providers. Transgender people are among the most discriminated against group in our society and Delaware has come a long way in passing laws that prevent discrimination. About 40% of transgender individuals try to commit suicide at least once based on non-acceptance and unavailability of health care. Mr. Purpura stated that he thinks the State is trying to not only provide necessary health care but a much safer environment to their transgender employees so they thrive as employees, increase productivity and he asked the SEBC to consider those objectives when they vote on inclusion of this coverage.

### **Other Business**

Treasurer Simpler shared that he made a proposal to Director Maxwell and wanted other committee members to hear which was given the intense period with this RFP, if maybe WTW could reach out to the members of SEBC, if they prefer to be contacted, to speak individually to each member and establish a baseline of understanding of that committee member's appreciation for the issues and to hear their hot items as it may be difficult to extract in the public meeting setting. If the consultants could reach out or provide a questionnaire it could serve helpful to WTW and help them steer the SEBC towards consensus and accelerate the committee's capacity to come together around making the various decisions put before them.

Director Maxwell stated that he would be open to the proposal as long as SBO could attend those conversations with the consultant to be part of that process and to avoid playing catch up.

Ms. Nestlerode expressed appreciation on the extra meetings scheduled for the RFP process and thanked Ms. Rentz and Ms. Lakeman for their efforts.

### **Motions**

Director Maxwell asked for a motion for approval of the May 13, 2016 SEBC Minutes. Secretary Cook made the motion and Treasurer Simpler seconded the motion. Upon unanimous voice approval, the motion passed.

A motion was requested to approve the changes as shown in the Disability Insurance Program Rules and Regulations that were reviewed in detail. Mr. Klopp made the motion and Secretary Landgraf seconded the motion. Treasurer Simpler abstained from voting as he was not present for the discussion. All other members voted in favor of the motion. The motion passed.

A motion was requested to extend medical coverage for transgender individuals under the GHIP health plans and to remove the current exclusion under the benefit plans. The motion was made by Secretary Cook. Ms. Nestlerode seconded the motion. Discussion on the motion occurred with Treasurer Simpler commenting that given the public testimony from Mr. Purpura, would he be able to provide further insight into the cost estimates. Mr. Purpura commented that the cost estimates were reasonable; however, other States have later determined that their initial cost estimates were overstated. The estimate of 1 in 7,000 members is reasonable with recent studies showing costs ranging from \$20,000 to \$40,000 per person. Mr. Klopp voted against the motion and all other members voted in favor of the motion. The motion passed.

Director Maxwell stated the next SEBC meeting is scheduled for Friday, June 24, 2016 and will be reviewing the first draft of the Health Care RFP.

A motion to adjourn the meeting was made. Secretary Landgraf made the motion and Treasurer Simpler seconded. Upon unanimous voice approval, the meeting was adjourned at 3:35 p.m.

Respectfully submitted,

Lisa Porter  
Executive Secretary  
Statewide Benefits Office