Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Commission Meeting

June 17, 2021

(Public Notice: G.L. C-30A, Sec. 20, June 14, 2021)

Agenda

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

	Topic	Speaker	Time
I.	Approval of 05/20/2021 Minutes (VOTE)	Valerie Sullivan, Chair	8:30-8:35
II.	Executive Director's Report (INFORM) • Calendar • Human Resources • Communications/Legislation/Municipalities • Dependent Care Assistance Plan (DCAP) • Office Move Update • COVID-19 • Engagement / Conjoint Survey • Health Care Consultant and Life/LTD contracts to be signed	Matthew Veno, Executive Director & Members of Senior Staff	8:35-8:45
III.	Cost Drivers (INFORM) • Prescription Drugs	Deven Shah, RPh, MBA Willis Towers Watson Jannine Dewar, Manager of Pharmacy & Ancillary Benefits	8:45-9:30
IV.	Cost Trends (INFORM)	Center for Health Information & Analysis –Ray Campbell, Executive Director Health Policy Commission – David Seltz, Executive Director; David Auerbach, Senior Director of Research and Cost Trends	9:30-10:30
	Commission in Recess		10:30-10:40
V.	Health Equity (INFORM)	Margaret Anshutz, Manager, Healthcare Analytics, GIC Center for Health Information & Analysis –Ray Campbell, Executive Director Health Policy Commission – David Seltz, Executive Director; David Auerbach, Senior Director of Research and Cost Trends	10:40-11:15
VI.	CFO UPDATE (INFORM & VOTE) • FY22 Trust Fund Authorization Request (VOTE) • COVID claims update (INFORM) • FY21 spending to date (INFORM)	Jim Rust, Chief Financial Officer	11:15-11:30
VII.	Annual Enrollment (INFORM & UPDATE)	Paul Murphy, Director Operations Cameron McBean, Manager, Health & Ancillary Benefits	11:30-11:50
VIII.	Other Business/Adjournment	Valerie Sullivan, Chair	11:50-12:00

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

I. Approval of Minutes (VOTE)

Motion:

That the Commission hereby approves the minutes of its meeting held on May 20, 2021 as presented.

- Valerie Sullivan, Chair
- Bobbi Kaplan, Vice-Chair
- William Archibald
- Rebecca Butler
- Elizabeth Chabot
- Adam Chapdelaine
- Edward Tobey Choate
- Christine Clinard
- Tamara P. Davis
- Gerzino Guirand
- Jane Edmonds
- Joseph Gentile
- Eileen P. McAnneny
- Patricia Jennings
- Melissa Murphy-Rodrigues
- Anna Sinaiko
- Timothy D. Sullivan

II. Executive Director's Report (INFORM)

- Calendar
- Human Resources
- Communications/Legislation/Municipalities
- Dependent Care Assistance Plan (DCAP)
- Office Move Update
- COVID-19
- Engagement / Conjoint Survey
- Health Care Consultant and Life/LTD contracts to be signed

Matthew Veno, Executive Director
&
Members of Senior Staff

II. Executive Director's Report: Calendar

Commonwealth of Massachusetts
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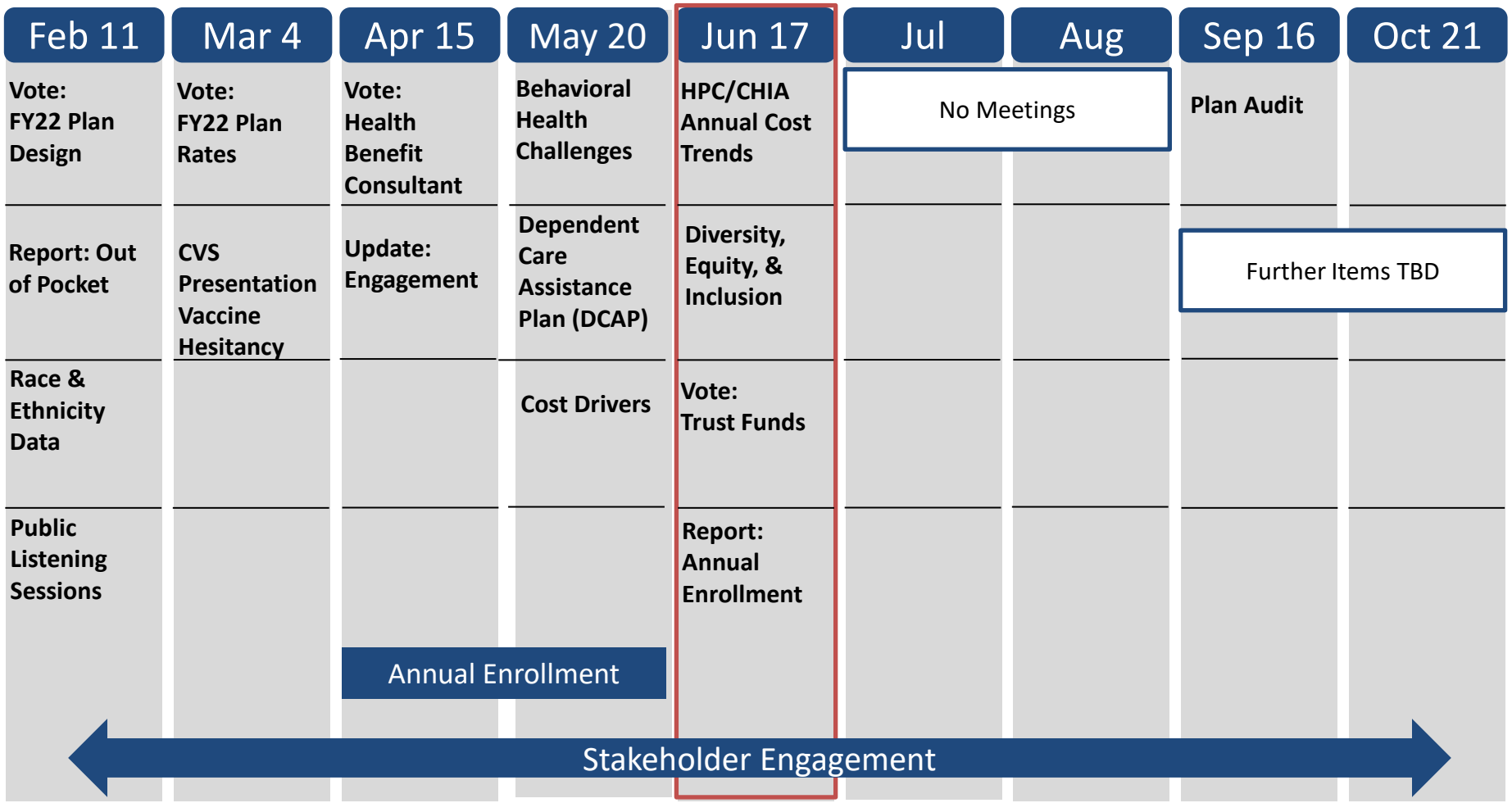

II. Executive Director's Report (INFORM)

- Human Resources
- Communications/Legislation/Municipalities
- Dependent Care Assistance Plan (DCAP)
- Office Move Update
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- Engagement / Conjoint Survey
- Health Care Consultant and Life/LTD contracts to be signed

Matthew Veno, Executive Director

&

Members of Senior Staff

III. Cost Drivers (INFORM)

- Prescription Drugs

Deven Shah, RPH, MBA
Willis Towers Watson
&
Jannine Dewar, Manager
Pharmacy & Ancillary Benefits

Agenda

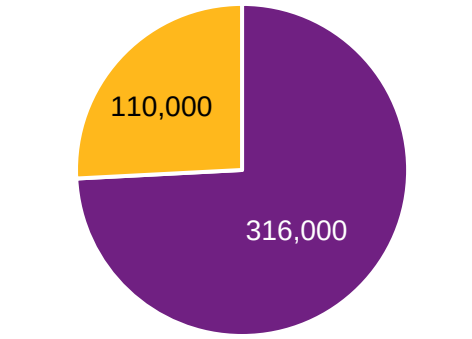
Topic
1. Pharmacy vendor relationships
2. Pharmacy cost drivers
3. Review of key performance metrics
4. Specialty pharmacy issues
5. Key takeaways and next steps

GIC's PBMs: Who they are and what they do

CVS Health

EXPRESS SCRIPTS®

Estimated membership



Key Insights

- In FY19, the GIC moved to self-insured "carved-out" pharmacy arrangements with two national PBMs
  - ESI covers commercial members
  - CVS covers Medicare members
- These vendors integrate and coordinate with the GIC's medical vendors

Core Services of a PBM

Member Services

- Assist GIC members in navigating their prescription drug benefit
- Assist members in managing complex conditions

Claims Administration

- Administer benefit at the pharmacy, i.e., the GIC cost and member cost, generic substitution
- Provide mail order services for chronic and specialty injectable drugs

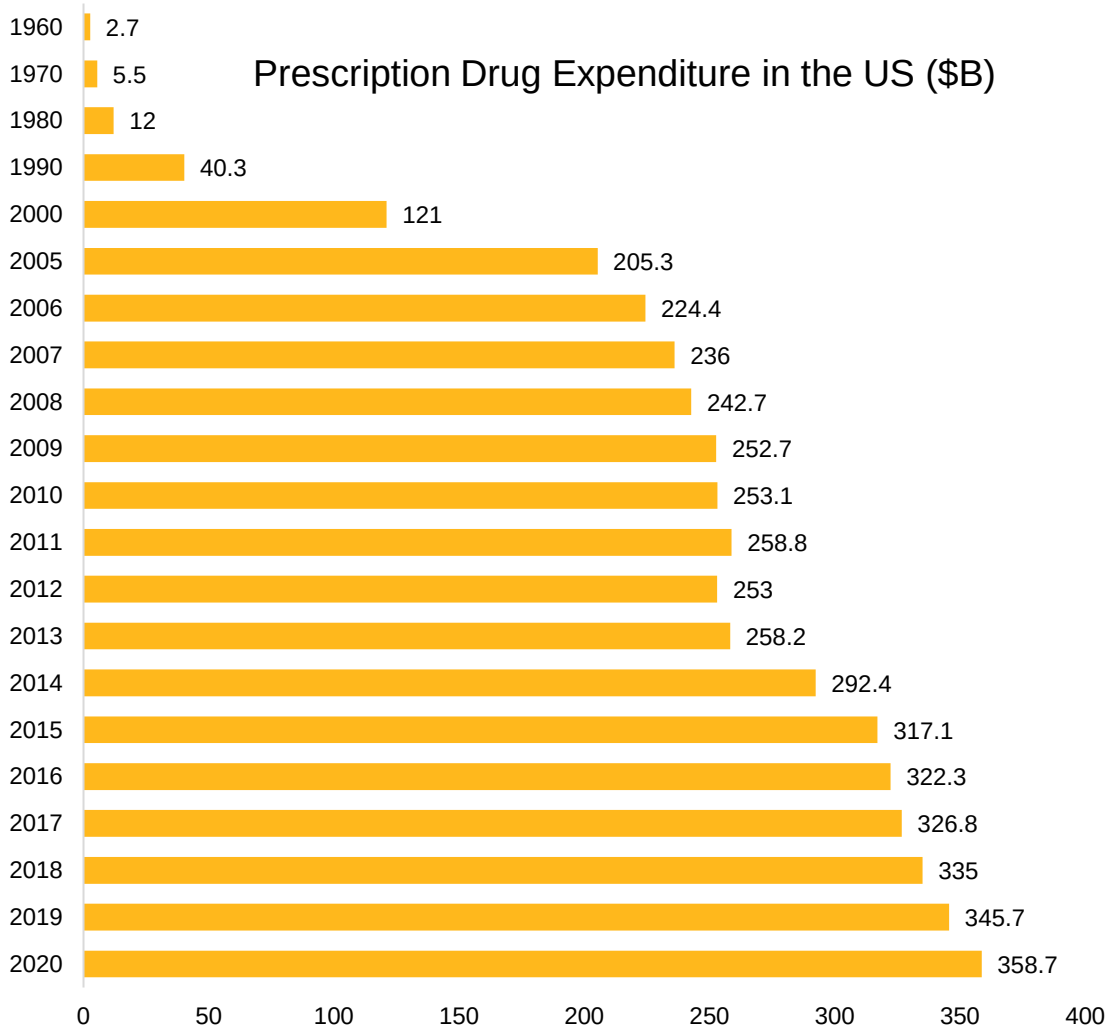
Financial

- Negotiate drug prices with retail pharmacies
- Negotiate drug prices and rebates with manufacturers

Care Management

- Develop new programs aimed at controlling costs and improve member outcomes

Drug Costs Continue to Rise



Source: CMS, https://www.statista.com/statistics/184914/prescription-drug-expenditures-in-the-us-since-1960/

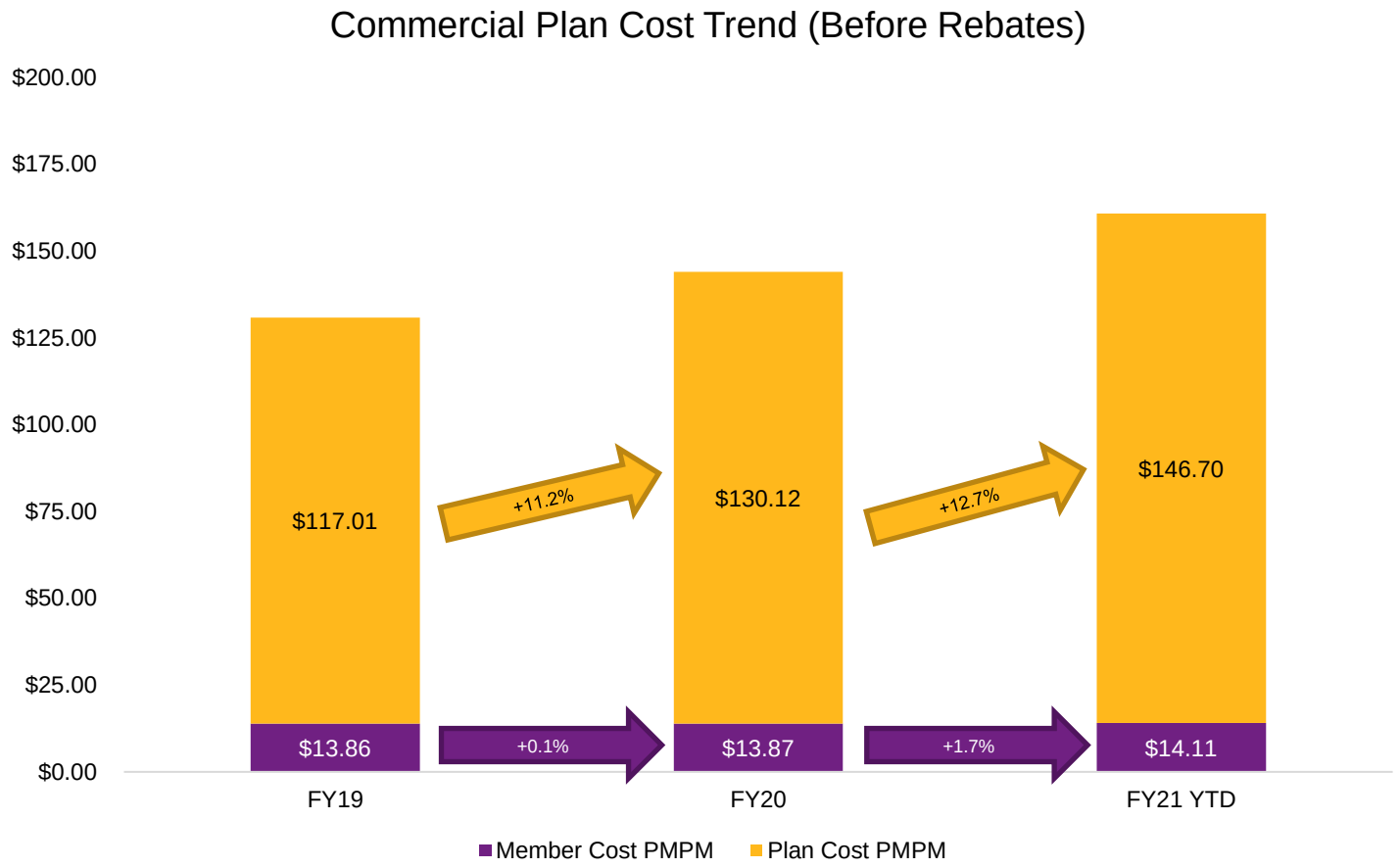
Key Insights

- Pharmacy costs represent roughly $900M annually and accounts for 30% of the GIC's total health care expense in FY20
- Medical and Pharmacy trend expected to exceed CPI for years to come
- The GIC specific trends outlined below drive increases in the GIC's budget rates
- Rx trends are approximately double of the Medical trend for the next few fiscal years

The GIC's projected future trends

Trend Projections	Non-Medicare	Medicare	Total
FY21 Medical	4.9%	2.3%	4.6%
FY22 Medical	4.7%	2.5%	4.5%
FY21 Rx	10.0%	9.6%	9.8%
FY22 Rx	9.0%	8.0%	8.5%

Milliman Data showing PBM cost growth – Premium and OOPM



Key Insights

- Total pharmacy costs are a combination of plan and member out-of-pocket costs
- GIC's member copayments and out-of-pocket costs have remained the same for several years
- The GIC pays for majority of the drug cost, with members paying a portion based on their contribution level
- Higher plan spend results in increased premiums every year

Why are drugs so expensive?

- Drugs are often covered by patents, which allow pharmaceutical companies to set prices without competition
- Even drugs that are off-patent frequently have few producers, and can be subject to huge price increases
- Biologic drugs are more difficult to manufacture and cost more. Biosimilars will offer much smaller discounts than generics of “small molecule” medications
- The FDA is prohibited from considering price upon drug approval
- Medicare, the largest drug purchaser, is prohibited from negotiating drug prices
- The US, unlike most other developed countries, does not regulate drug prices

Key Insights

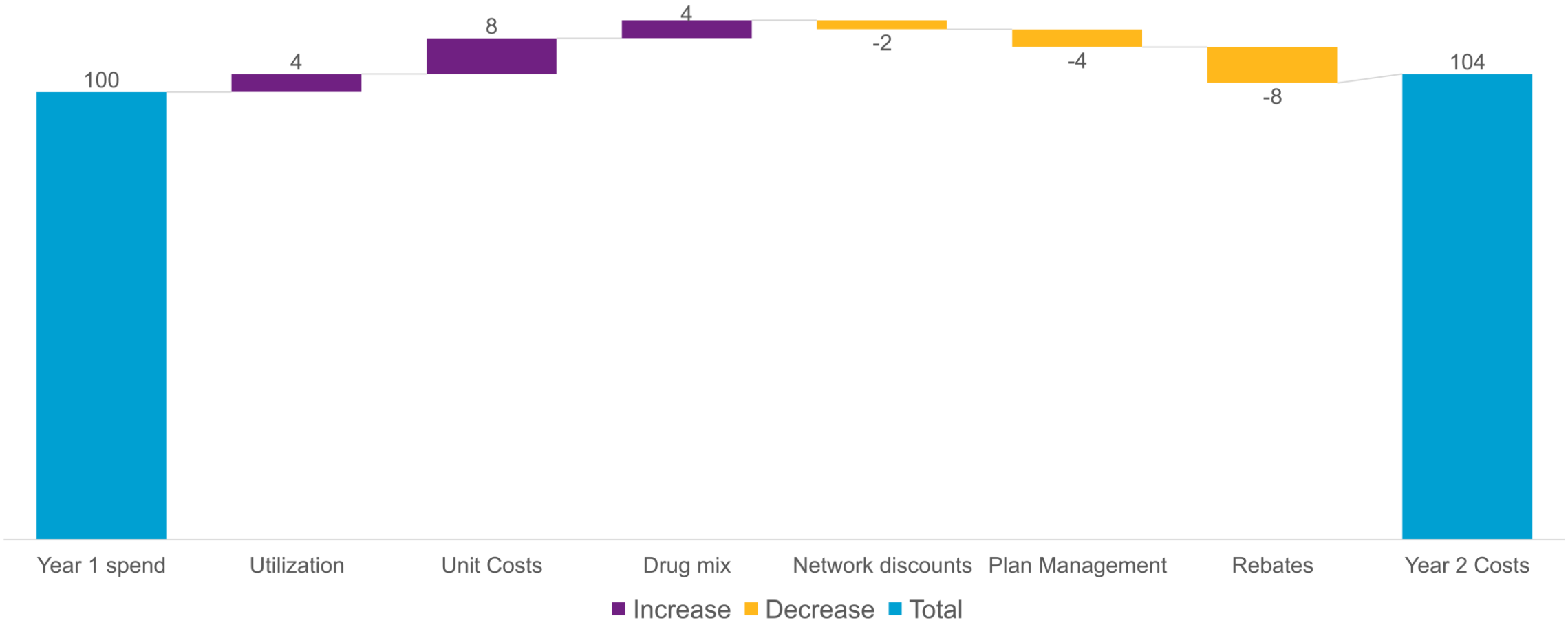
How does the GIC combat high drug costs and ensure the best value for the state and its members?

- The GIC plan encourages use of generics and lower cost pharmacies for chronic medications
- Current formularies (preferred drug lists) steer members toward highest value drugs
- Strong vendor contracts and oversight ensure best available pricing
- Members pay the lowest cost between the discounted price, pharmacy’s U&C costs and plan copays
- Price transparency tools allow members to price shop for individual drugs and dosages

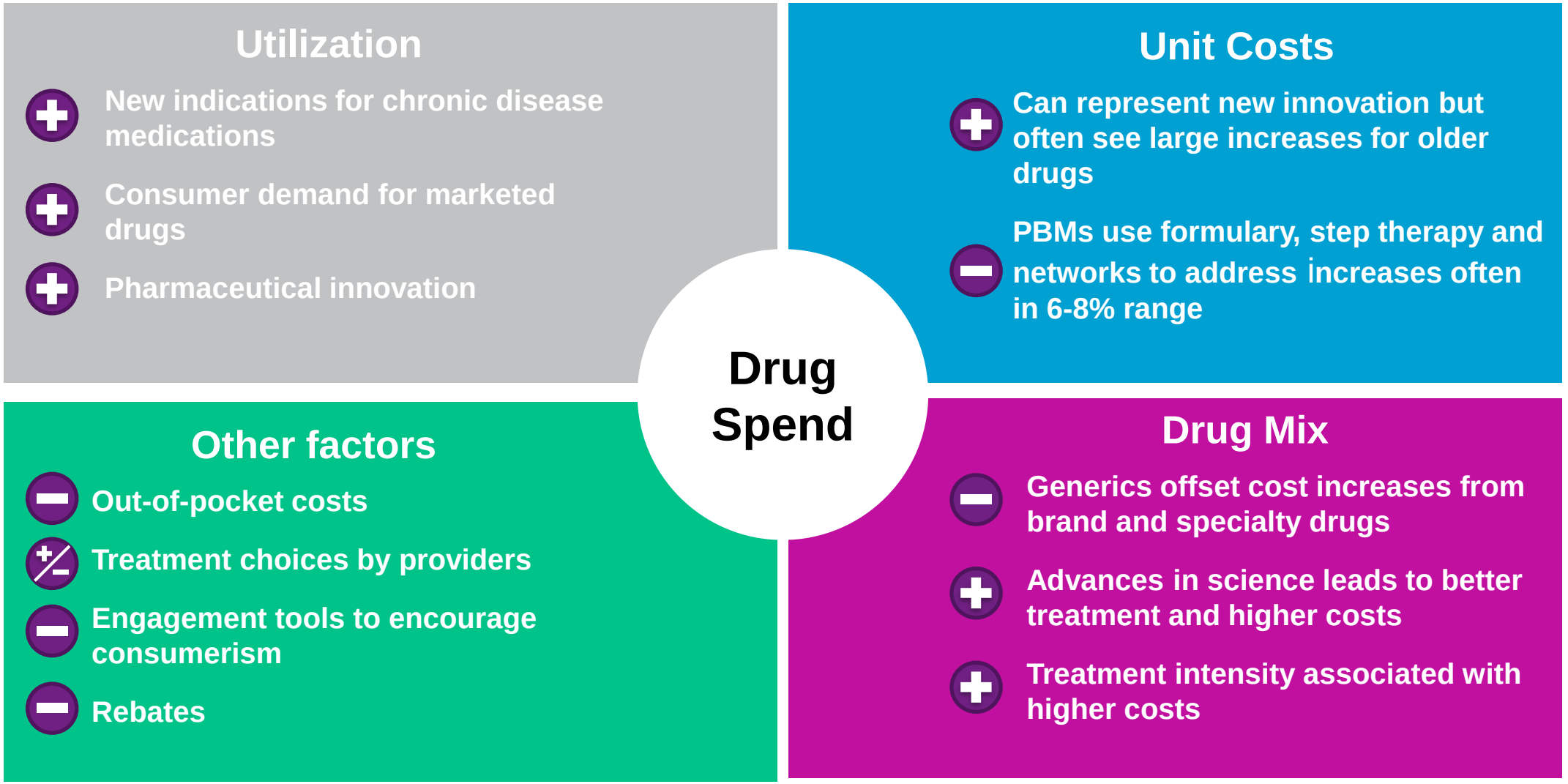
What are the components of pharmacy trend?

Illustrative Example

Pharmacy cost is influenced by increasing and decreasing cost factors



Factors that Influence Drug Trend

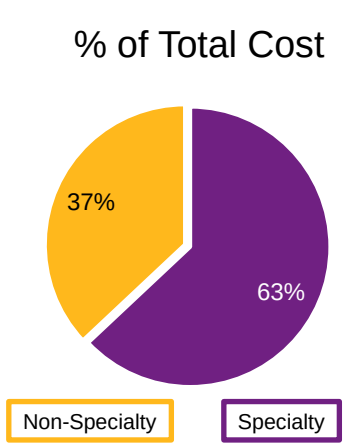


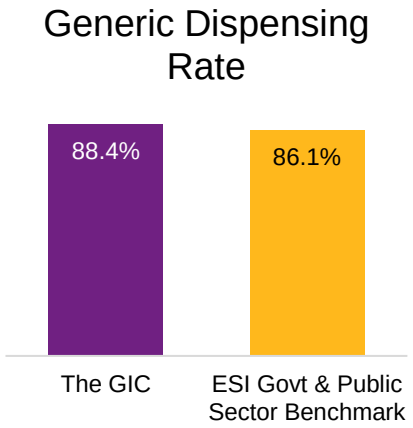
Drug Mix: Cost and Utilization

Type	Description	Cost per script	% of Scripts
Generic Drugs	▪ Identical to brand-name drug in dosage, safety, strength, how it is taken, quality performance and intended use ▪ Single-source generics – A single manufacturer is given sole rights to market the generic ▪ Multi-source generics – Multiple manufacturers compete in the open market to market their generics	$22	87%
Multi-Source Brand	▪ Brand version of a drug when it is available in both brand-name and generic versions from a variety of manufacturers	$306	1%
Single-Source Brand	▪ Drug under patent protection that is sold under a brand name and is available from only one manufacturer. No generic version is available	$470	10%
Specialty Drug	▪ Medication and biologicals used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia and multiple sclerosis among others ▪ Specialty drugs can include drugs administered by a health care professional, self-injected or taken by mouth ▪ Specialty drugs can require an enhanced level of service, close supervision or clinical management. They are also extremely expensive	$6,297	2%

Cost per script based on WTW Collaborative data. % of Scripts is GIC specific commercial population data

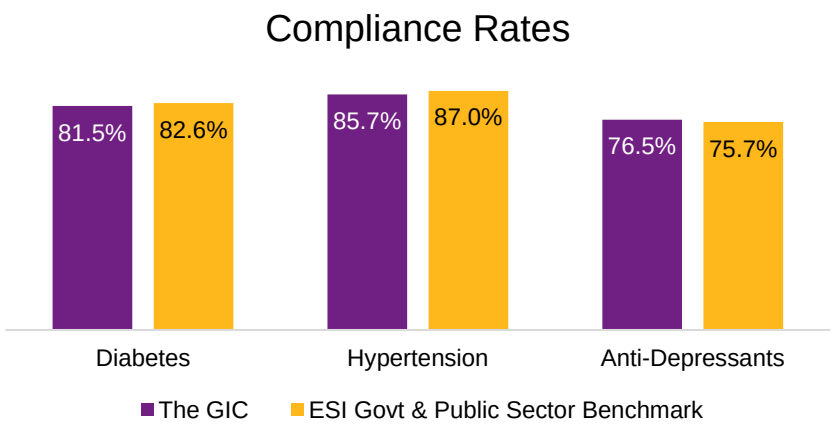
Key Performance Metrics – Commercial (ESI)

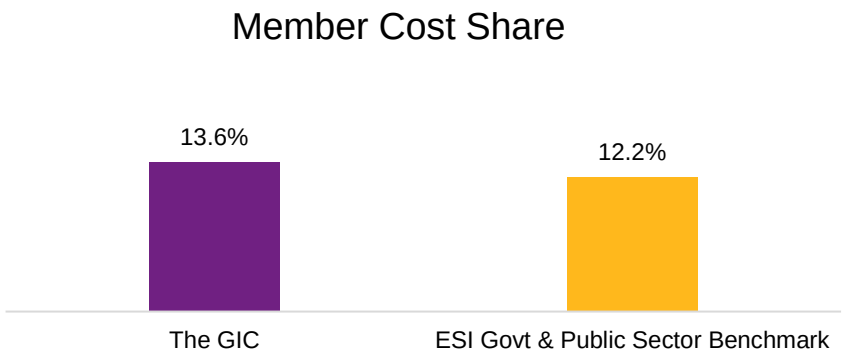




Key Insights

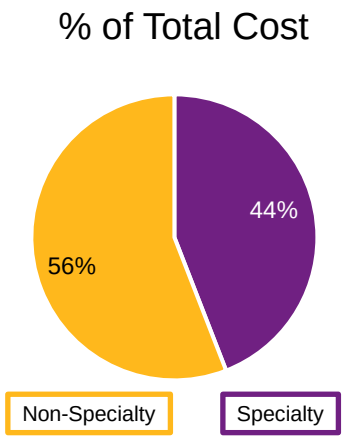
- Specialty spend represents a gross (before rebates) trend of 11.9% driven primarily by increased utilization
- Member share consistent with other large Government peers and lower than private employers (typically in the 15-20% range)
- Higher generic dispensing rate validates efficiency of the plan design and PBM's ability to steer towards lower cost alternatives
- GIC saw a 15% reduction in members on short-acting opioids and 27% reduction in members on long-acting opioids

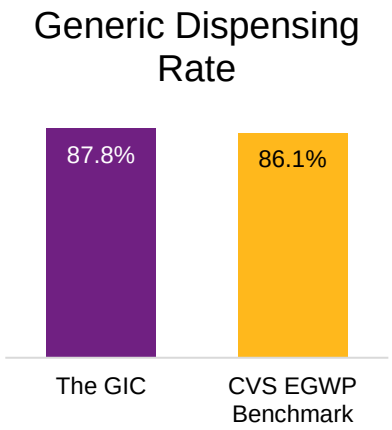




Data based on ESI reporting FY2020 compared to FY2019

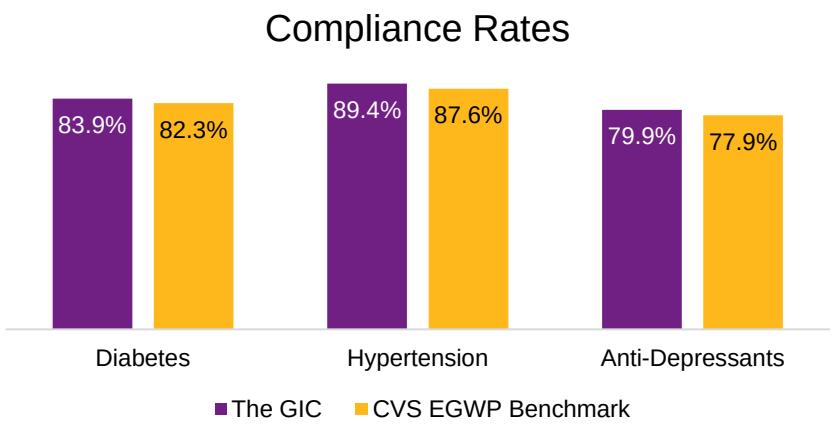
Key Performance Metrics – Medicare (CVS)

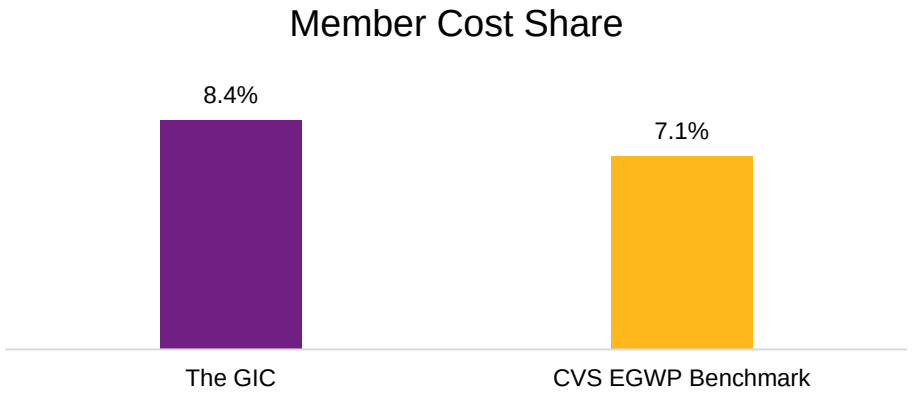




Key Insights

- Specialty spend represents a gross (before rebates) trend of 15.6% driven primarily by increased utilization
- Member share consistent with other large Government peers and much lower than private employers
- The GIC covers many non-essential drugs making the plan richer than benchmark
- Adherence rates for some key chronic condition medications are similar to other Medicare populations

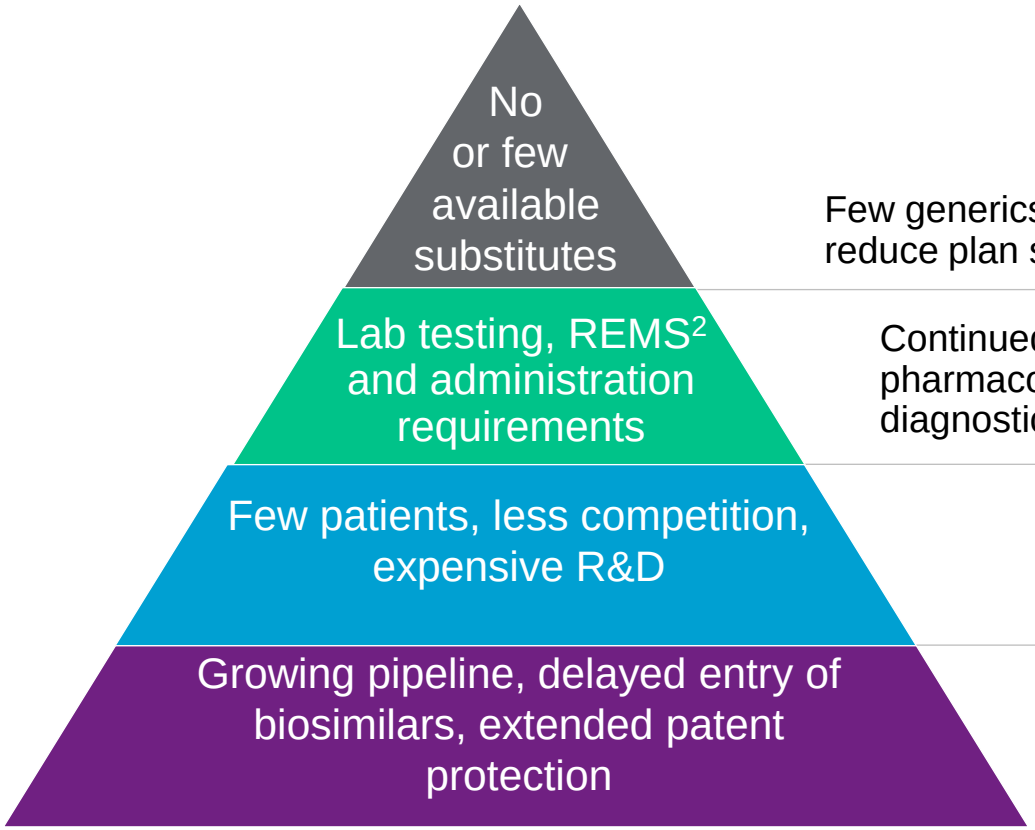




Data based on CVS reporting CY2020 compared to CY2019. Benchmark represents CVS' EGWP book of business

Key Drivers of Specialty Costs Rising in Recent Years

Specialty drug utilization and cost continue to increase, accounting for nearly half of total drug spend. Specialty spend could reach **$310 Billion** across the pharmacy and medical benefit **by 2030**[1]



Few generics mean fewer low-cost options to reduce plan sponsor/patient costs

Continued advances in genetic testing and pharmacogenomics give rise to requirements for costly diagnostics and administration (e.g., cellular therapy)

Lack of competition allows Pharma to charge exorbitant drug prices for much needed therapies. Few patients mean spreading cost across a smaller group of users

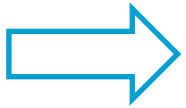
Pipeline includes ‘me too’ therapies as well as $1M+ gene therapies. Relatively few biosimilars are on the market today and biosimilar market launches are slow when a patent finally expires

[1]CVS Health 2019 Drug Trend Report
[2] Risk Evaluation and Mitigation Strategy

GIC's Pharmacy Plan Updates and Savings Over the Years

Overall Pharmacy Results

- In FY2019 and FY2020, ESI's pharmacy management programs delivered $481M in cost avoidance through cost management programs
  - $91M from Utilization Management
  - $290M in rebates from manufacturers
  - $25M in formulary savings
  - $47M in Brand for Generics Program
  - $28M in specialty management
- In CY2019 and CY2020, CVS' pharmacy management programs delivered $556M in cost avoidance through cost management programs
  - $43M from Utilization Management
  - $301M in plan offsets and subsidies from EGWP
  - $212M in rebates from manufacturers



Key Takeaways

- The GIC continues to evaluate pharmacy programs that will benefit members and control overall cost
- In FY2021 the GIC has continued to focus on pharmacy:
  - The GIC implemented ESI's RationalMed Program, is a program that identifies safety issues and gaps in care. ESI reported cost avoidance of $10M YTD 2021
- The GIC contracts include rebate transparency and strong minimum guarantees
- The GIC conducted market checks to ensure contracts remain competitive with the market and audits validate that contracts are administered correctly
- Despite the efforts of the GIC and its PBM efforts, trend continues to outpace the savings opportunities, primarily driven by specialty drugs

*ESI reported Annual savings presented at 2018 annual review

Pharmacy Key Takeaways and Next Steps

The GIC pharmacy plan is running efficiently; programs provide high value

Strong member satisfaction with PBM partners

Specialty drugs continue to be the leading driver of pharmacy trend

Next Steps

- The GIC and WTW continue to monitor pharmacy program and vendors
- The GIC will provide further detail on the challenge of specialty drugs at a future Commission meeting

IV. **Cost Trends (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Ray Campbell, Executive Director, Center for Health Information and Analysis

David Seltz, Executive Director, Health Policy Commission

David Auerbach, Senior Director of Research and Cost Trends, Health Policy Commission

CHIA OVERVIEW AND UPDATE FOR THE GROUP INSURANCE COMMISSION

Ray Campbell

June 17, 2021

CHIA's Role

- Massachusetts places greater emphasis on measuring its healthcare system than any other state in the country.
- Massachusetts has a long history of innovation not only in healthcare delivery, but also in healthcare policy, which benefits from more data for evidence-based policy making.
- CHIA's mission is to create the factual foundation to support better healthcare policy in Massachusetts.
- CHIA has extensive authority to compel the submission of data from Massachusetts healthcare stakeholders.
- CHIA uses this authority to create and curate several major data assets that support evidence based policy making and program oversight. CHIA also releases numerous publications documenting key features and metrics of the system.

CHIA's Major Data Assets

CHIA receives more than 25,000 data submissions per year from more than 1,000 data submitters. CHIA's major data assets include:

- **Hospital discharge database:** Patient-level information on every acute and behavioral health hospital discharge in the state.
- **Emergency department database:** Patient-level information on every ED visit in the state.
- **All-Payer Claims Database:** Despite gaps, the APCD is a massive, powerful repository of claim-level data about healthcare delivery and finance. APCD 2.0 is coming soon.
- **Payer expenditure reports:** Annual submissions of aggregate spending and cost data broken out by product, service category, ZIP code, market segment, cost sharing, and more.

CHIA's Major Data Assets (continued)

- **Provider financial reports:** CHIA collects financial and cost information from hospitals, nursing homes, community health centers, and other types of providers.
- **Statewide surveys of employers and households:** Large surveys provide rich information about individuals, households, and employers.
- **Registered Provider Organizations:** CHIA and the HPC jointly collect information from medical groups on their financial condition and their clinical and contractual affiliations.

CHIA's Major Analytic Activities

While not mutually exclusive, the following categories capture CHIA's core capabilities and core thematic focus areas:

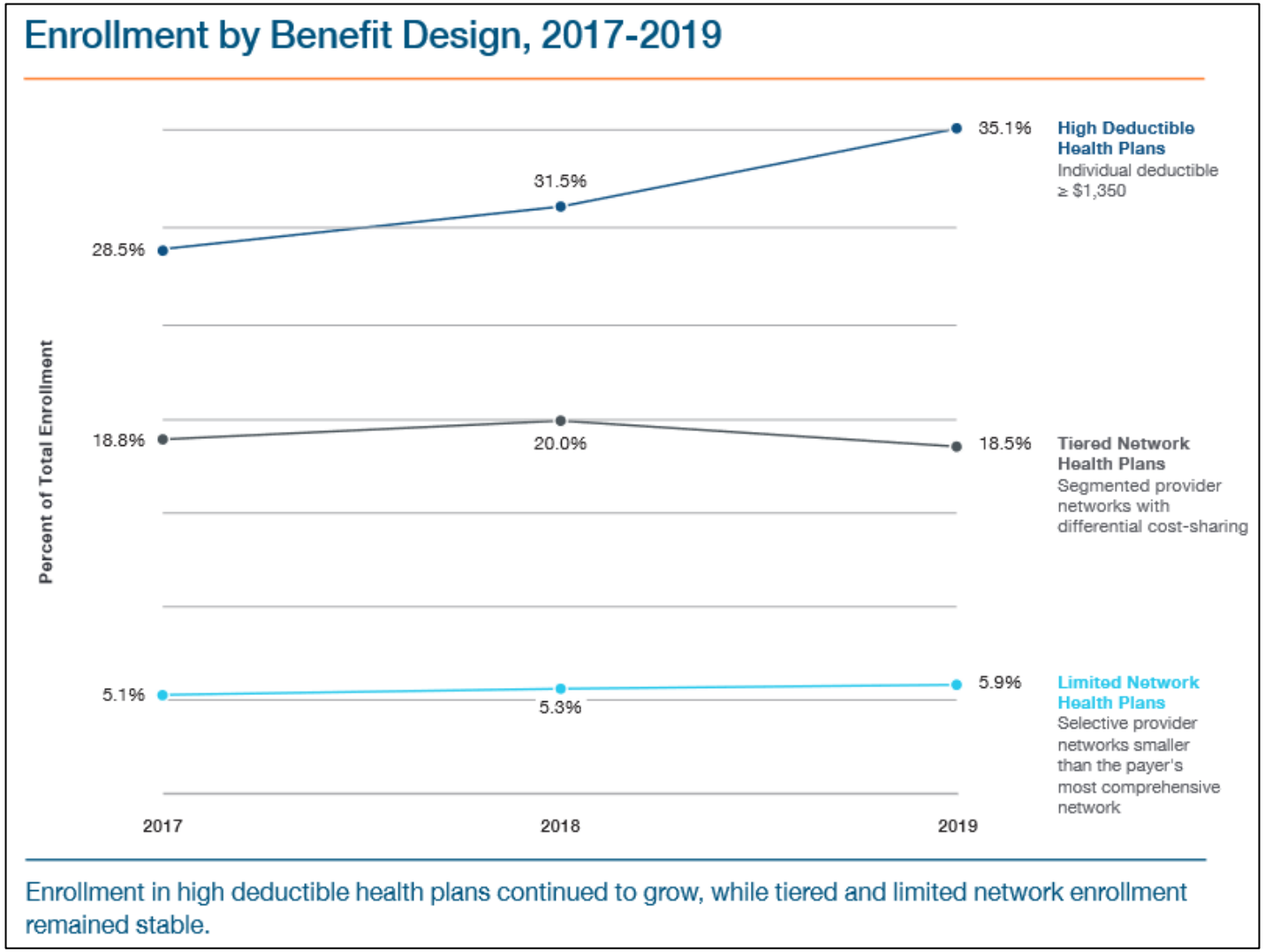
1. Healthcare spending and utilization
2. Provider finances and rate setting
3. Insurance coverage and healthcare affordability
4. Health equity and social determinants of health
5. Behavioral health
6. Provider and payer quality
7. Price transparency

CHIA's Major Analytic Activities (continued)

In addition to creating publicly available data and reports, CHIA also performs custom data and analytics work for external entities, primarily within Massachusetts state government.

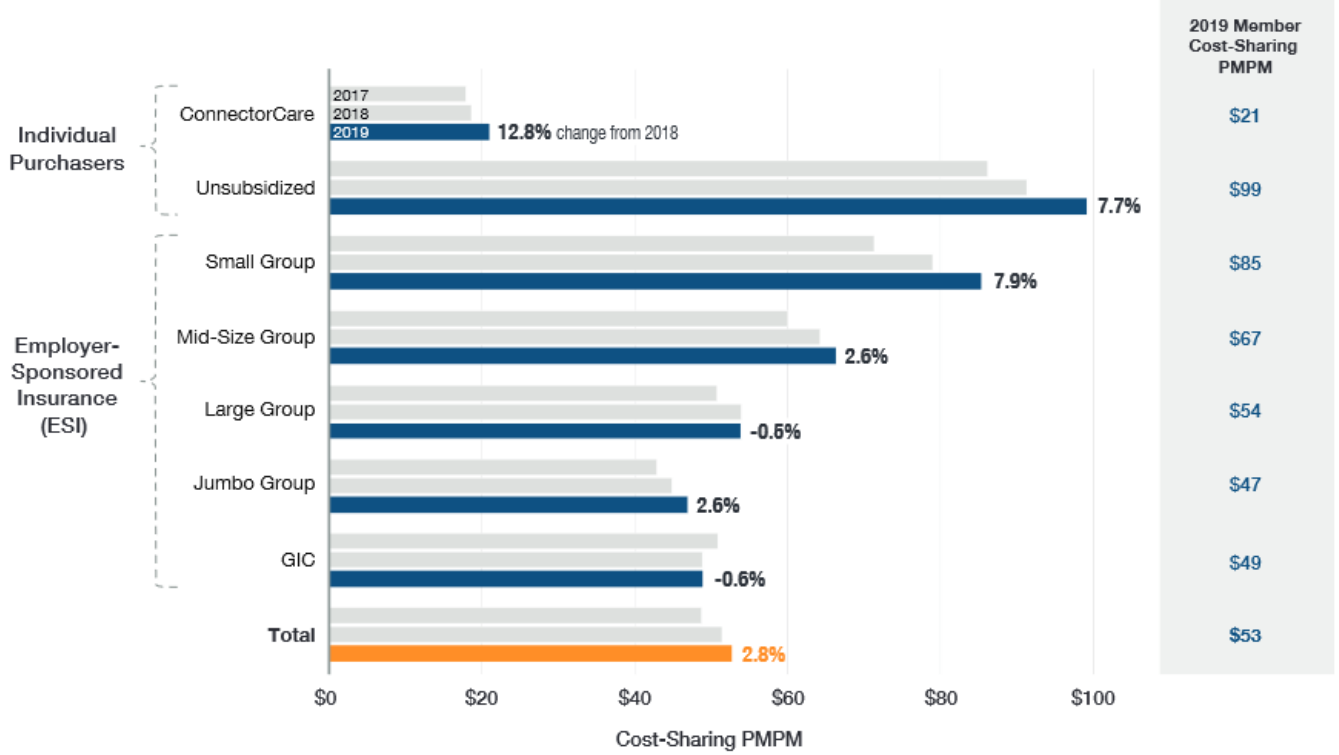
- Mandated benefit reviews for the Legislature
- Support the HPC with data, analyses, and referrals
- Inter-agency data and analytics sharing (AGO, SAO, DPH, MassHealth, EOHHS, Connector, DOI, GIC, others)
- Inter-agency data linking (e.g., Chapter 55 Opioid Study)
- Payer/Provider/Researcher data sharing
- Responding to major healthcare system events

CHIA's 2021 Annual Report – Key Slides



CHIA's 2021 Annual Report – Key Slides

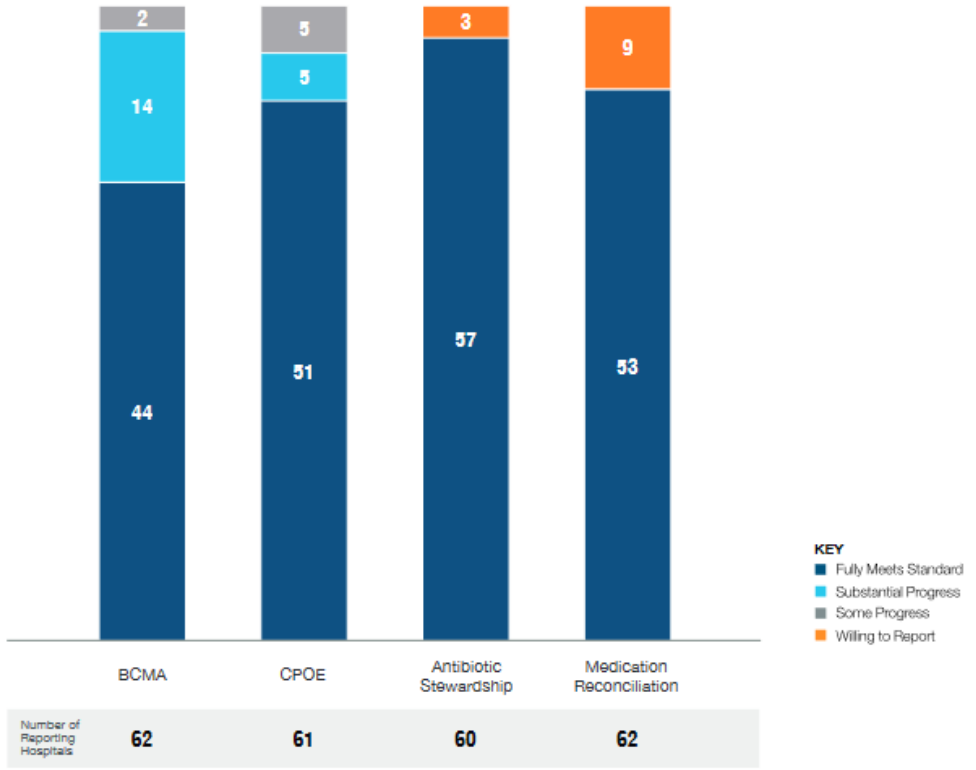
Cost-Sharing by Market Sector, 2017-2019



While average member cost-sharing growth slowed from 2018 to 2019, this trend was limited to larger employer groups.

CHIA's 2021 Annual Report – Key Slides

Number of Hospitals Meeting Leapfrog Standards for Safe and Appropriate Medication Use, 2019



In 2019, the majority of reporting hospitals fully met the Leapfrog standard for BCMA, CPOE, Antibiotic Stewardship, and Medication Reconciliation.

CHIA.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Presentation to the Group Insurance Commission

June 17, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

- **Introduction to the HPC**
- Total Health Care Spending Growth
- Hospital Prices
- Hospital Outpatient Spending
- Total Medical Expenses by Provider Group
- Specialty Drugs
- Low Value Care
- The HPC and Health Equity

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

HPC

The HPC Board of Commissioners are appointed by the Governor, Attorney General, and State Auditor and oversee the work of the agency.

Governor
Charles Baker

- Chair with expertise in health care delivery
- Primary care physician
- Expertise in health plan administration and finance
- Secretary of Administration and Finance
- Secretary of Health and Human Services

Attorney General
Maura Healey

- Expertise as a health economist
- Expertise in behavioral health
- Expertise in health care consumer advocacy

State Auditor
Suzanne Bump

- Expertise in innovative medicine
- Expertise in representing the health care workforce
- Expertise as a purchaser of health insurance

Health Policy Commission Board
Dr. Stuart Altman, Chair

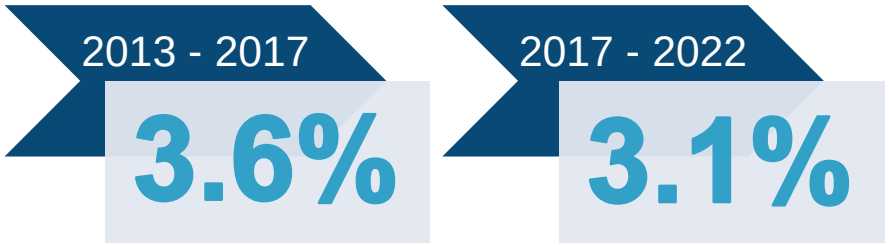
Executive Director
David Seltz

Advisory Council

Health Care Cost Growth Benchmark

- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state's long-term economic growth rate

Health care cost growth benchmark:



- If target is not met, the Health Policy Commission can require health care providers and health plans to implement **Performance Improvement Plans** and submit to strict public monitoring

TOTAL HEALTH CARE EXPENDITURES

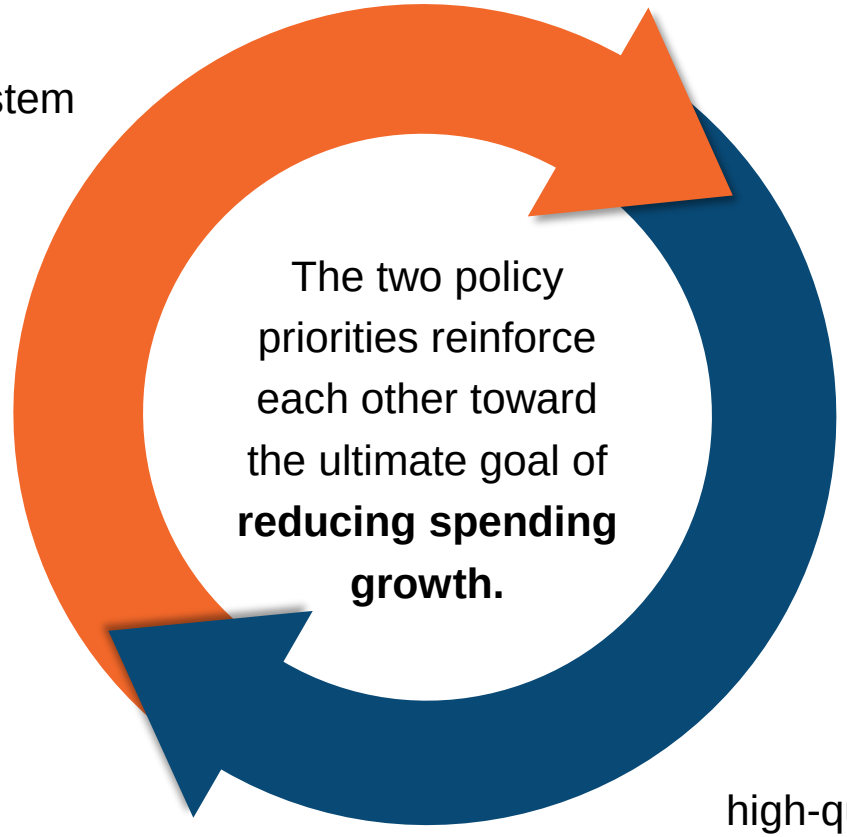
Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

The HPC promotes two priority policy outcomes that contribute to reducing health care spending, improving quality, and enhancing access to care.

Strengthen market functioning and system transparency



Promote an efficient, high-quality delivery system with aligned incentives

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Introduction to the HPC
- **Total Health Care Spending Growth**
- Hospital Prices
- Hospital Outpatient Spending
- Total Medical Expenses by Provider Group
- Specialty Drugs
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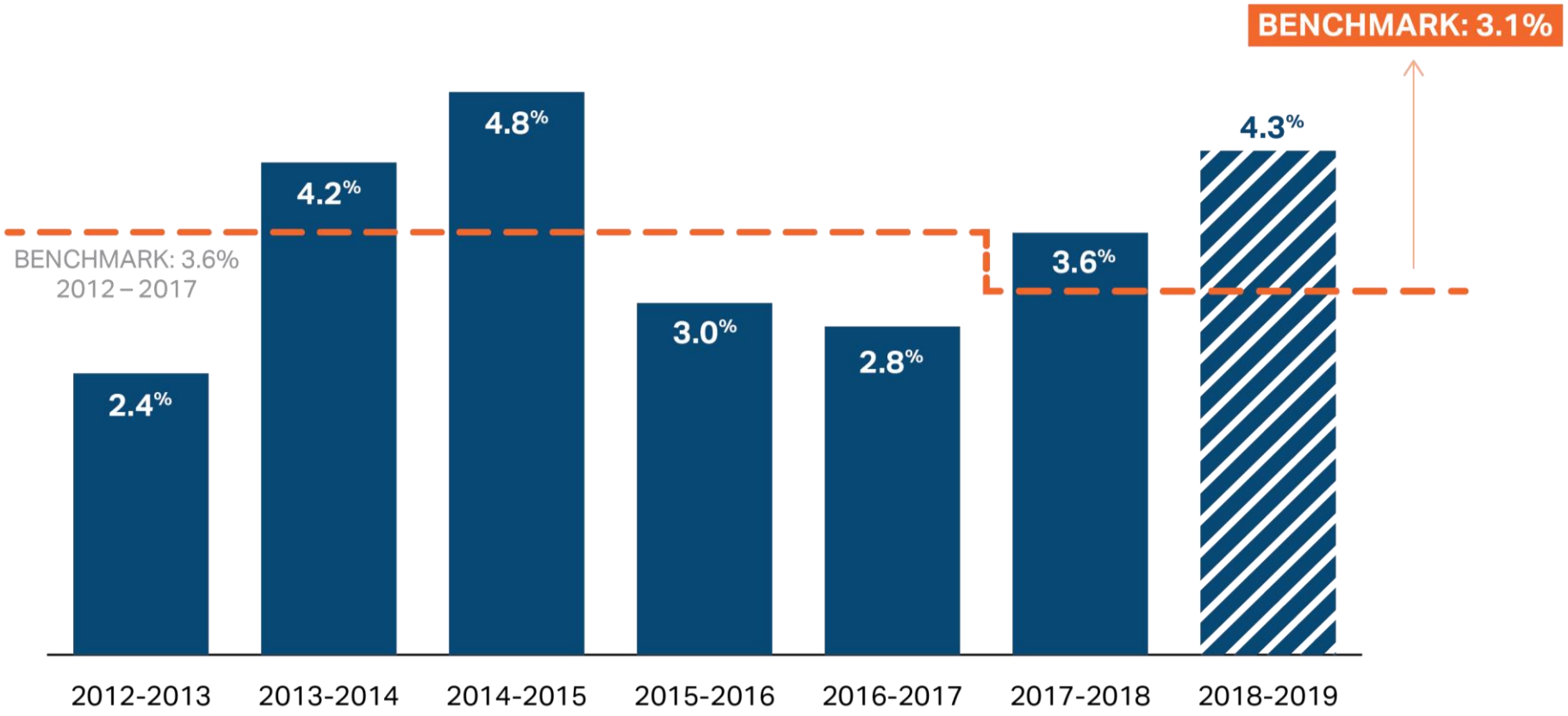
- The HPC and Health Equity

Growth in total health care spending accelerated the past two years and exceeded the benchmark in 2018 and 2019.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012-2019

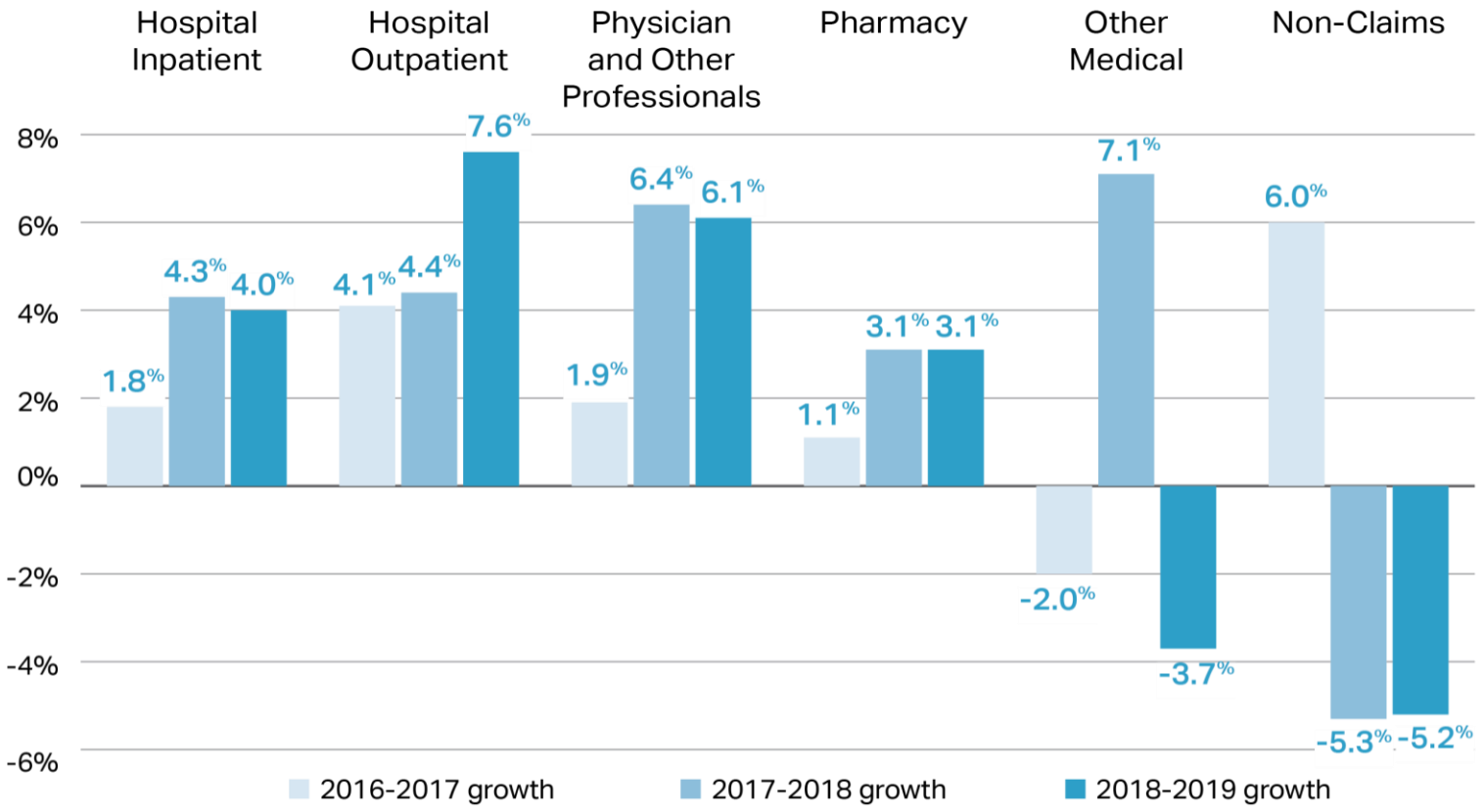


Average annual spending growth between 2012 and 2019 → 3.59%

Notes: 2018-2019 spending growth is preliminary.
Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2020.

Hospital outpatient and physician spending were key drivers of commercial spending growth in 2019.

Percentage annual growth in spending per capita for commercial members, 2016-2019



Hospital spending accounted for **54%** of spending growth in 2018-2019.

Notes: Pharmacy spending is net of rebates. Hospital spending includes facility spending only. Professional spending associated with hospital care is included in "Physician and other professionals". Other medical category includes long-term care, dental and home health and community health. Non-claims spending represents capitation-based payments.

Sources: Payer reported TME data to CHIA and other public sources; HPC analysis of data from Center for Health Information and Analysis Annual Report, 2020.

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Introduction to the HPC
- Total Health Care Spending Growth
- **Hospital Prices**
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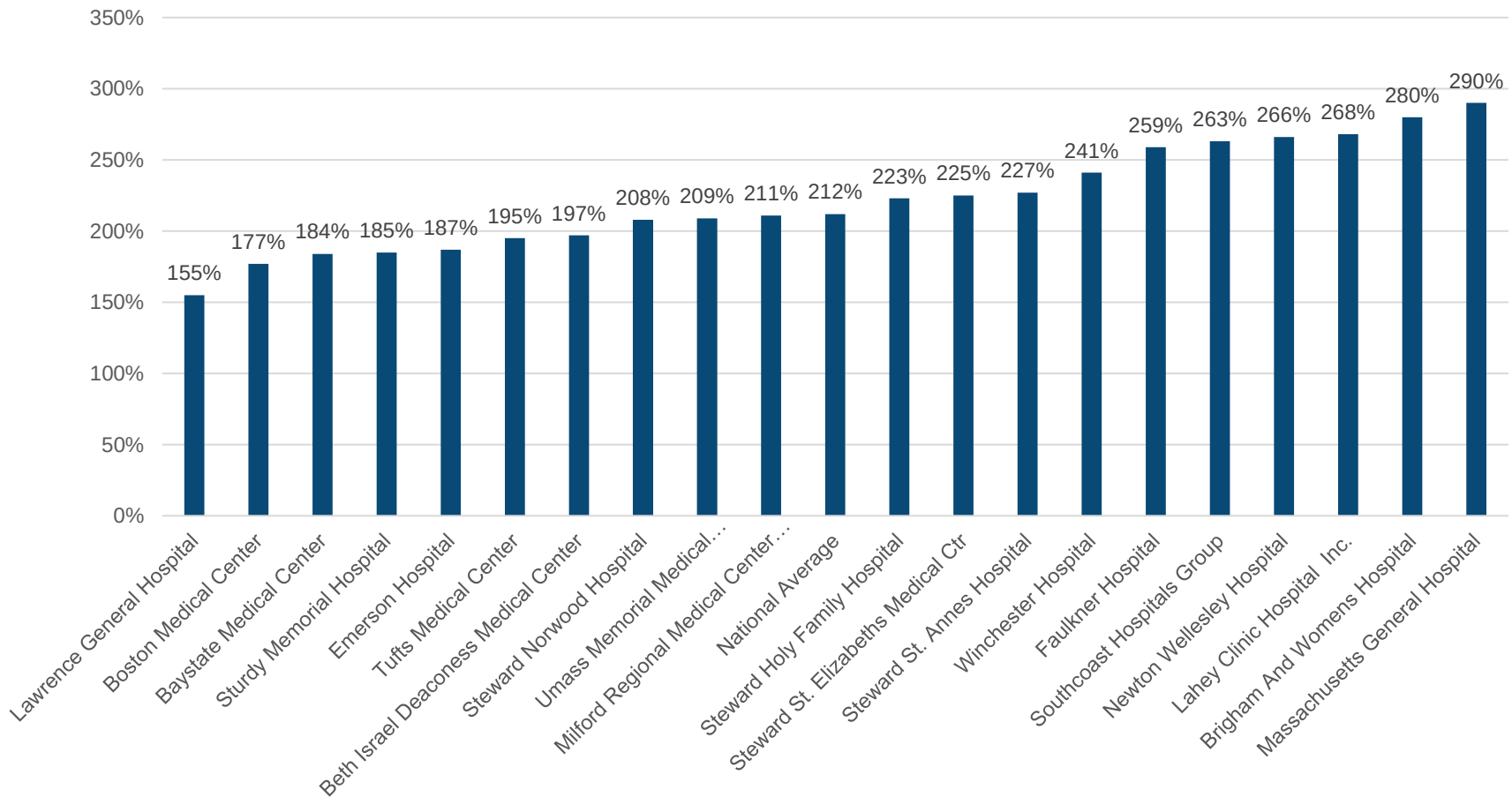
Commercial payment rates for hospital inpatient services vary twofold across Massachusetts hospitals, well exceeding Medicare rates.

Aggregate commercial hospital inpatient payments to hospital relative to what they would have received from Medicare, 2016-2018

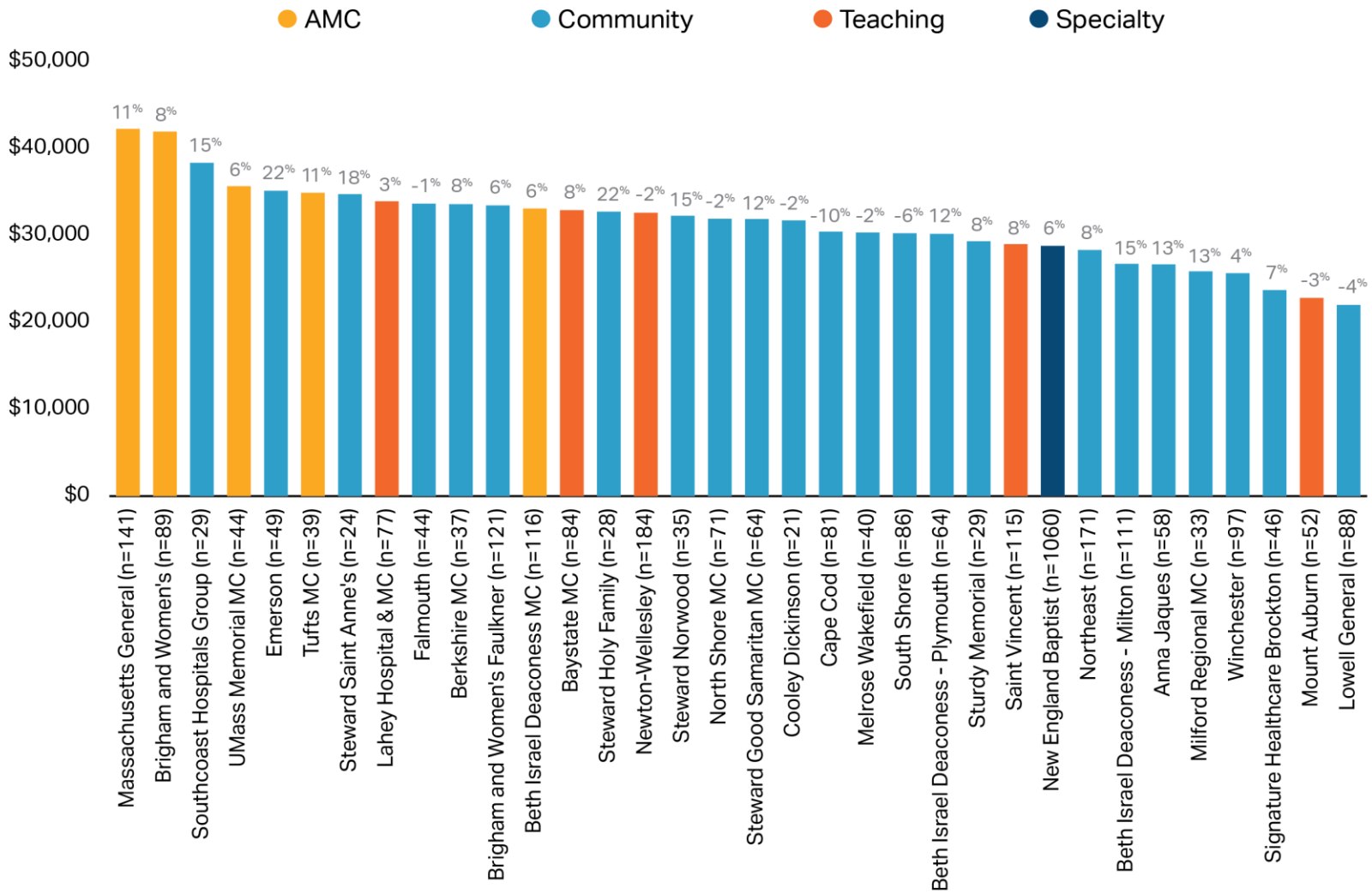


Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate spending from 2016-2018. Analysis based on commercial claims-level data contributed by self-insured employers and private health plans. Authors simulated Medicare payments using 3M software that applied Medicare payment rules to claims data. Data based on more than 100,000 services provided in MA hospitals. Hospitals excluded from figure if fewer than 100 inpatient stays. Specialty hospitals (Dana Farber, New England Baptist) also excluded.

HPC

The average payment for a major joint replacement stay varied from $42,000 (MGH) to $22,000 (Lowell General) in 2018.

2018 average major joint replacement payment with percent growth in average payment by hospital, 2016-2018

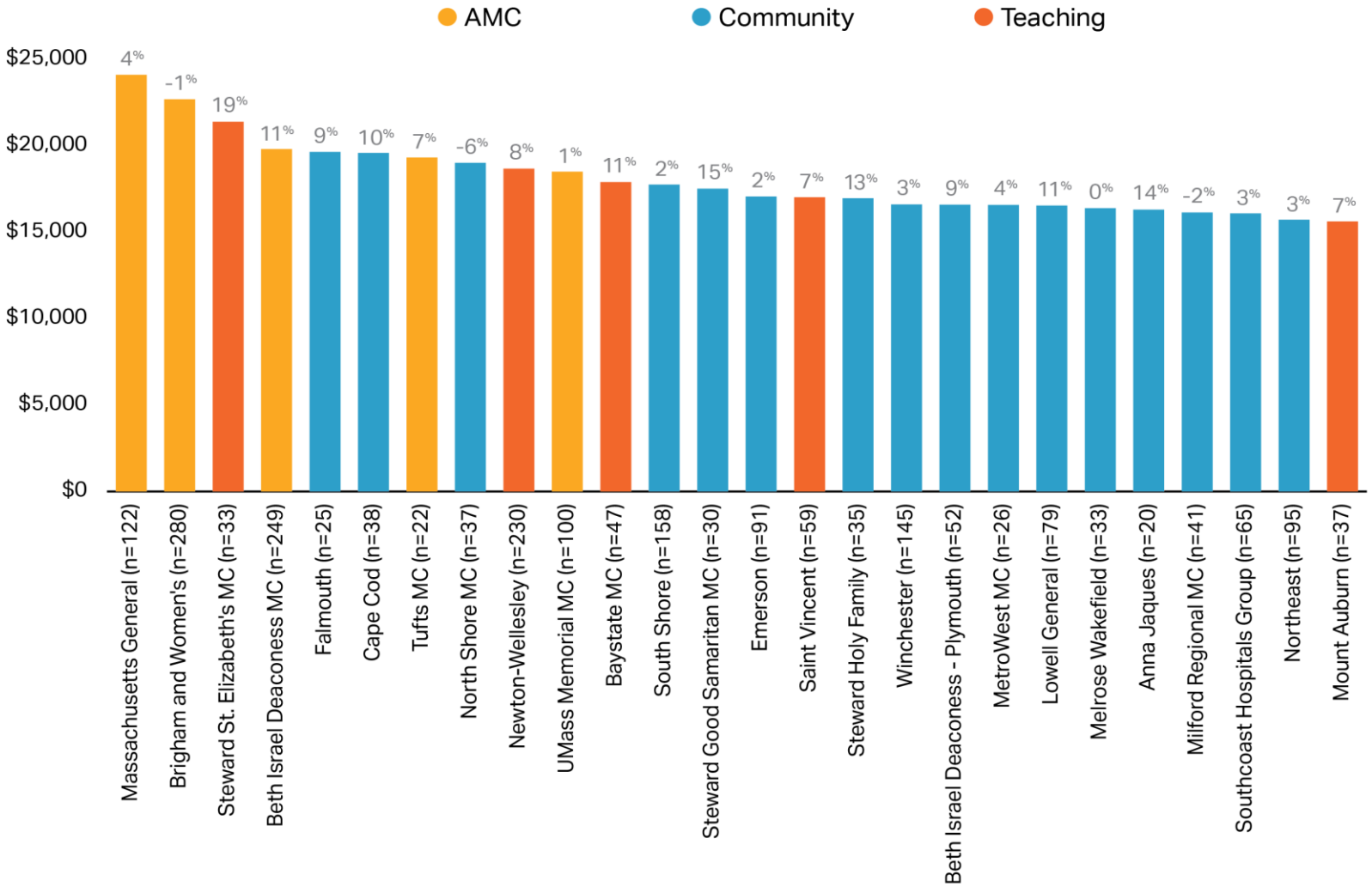


Notes: Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 470 (major joint replacement without major complication or comorbidity). Only hospitals with at least 20 inpatient stays for 2016 and 2018 were included in the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

The average commercial payment for a c-section delivery varied from $24,000 at Mass General to $15,600 at Mount Auburn hospital in 2018.

2018 average cesarean delivery payment with percent growth in average payment by hospital, 2016-2018

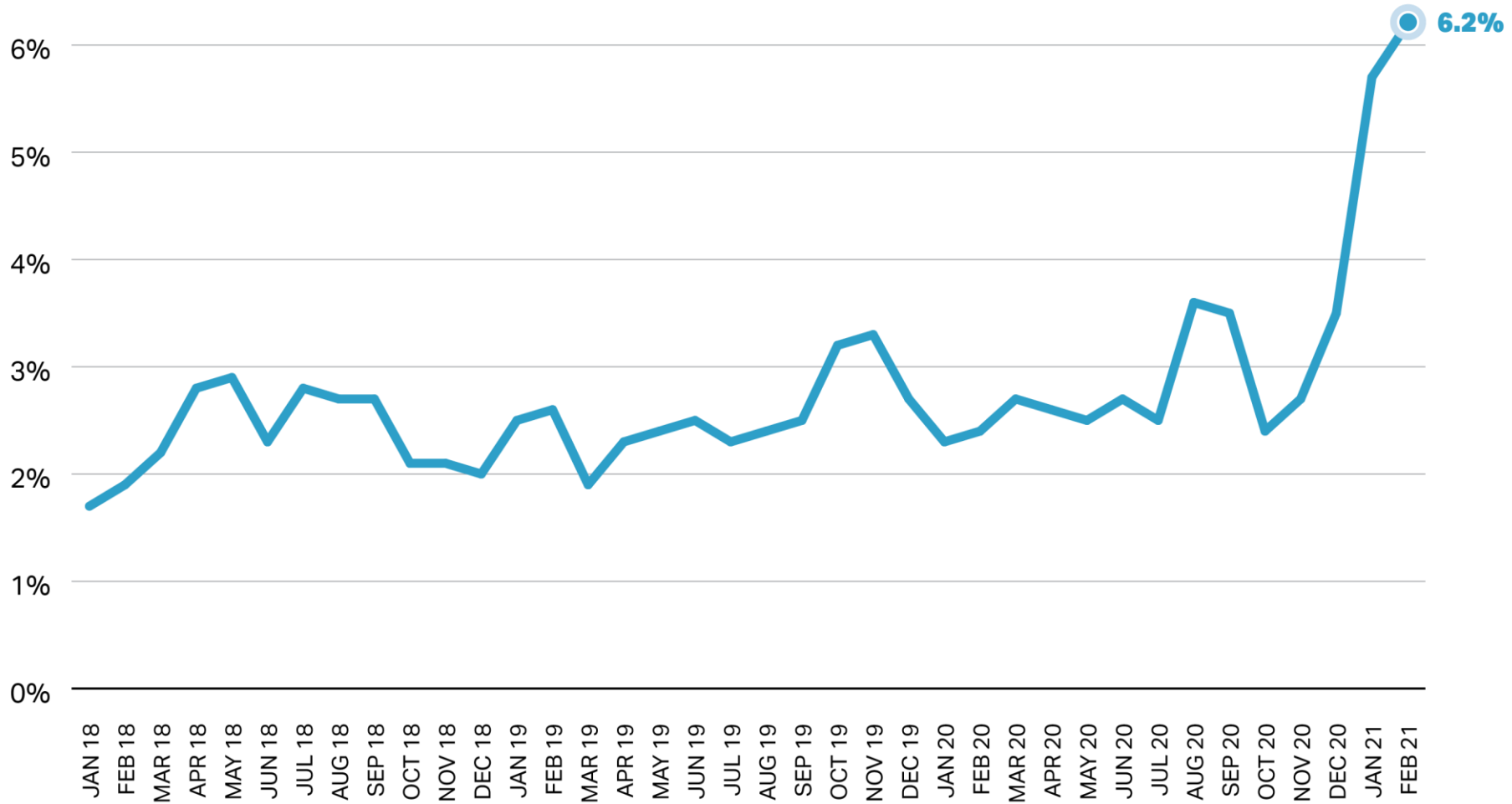


Notes: Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 766 (cesarean section without major complication or comorbidity). Only hospitals with at least 20 inpatient stays for 2016 and 2018 were included in the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

Nationally, commercial hospital prices grew rapidly toward the end of 2020.

National growth in commercial hospital prices relative to the same month, 12 months prior, Altarum Institute



Altarum Institute, Health Sector Economic Briefs. Data based on publication of Feb 19, 2021 – underlying data provided to the HPC by the Altarum Institute. https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Price-Brief_February_2021.pdf

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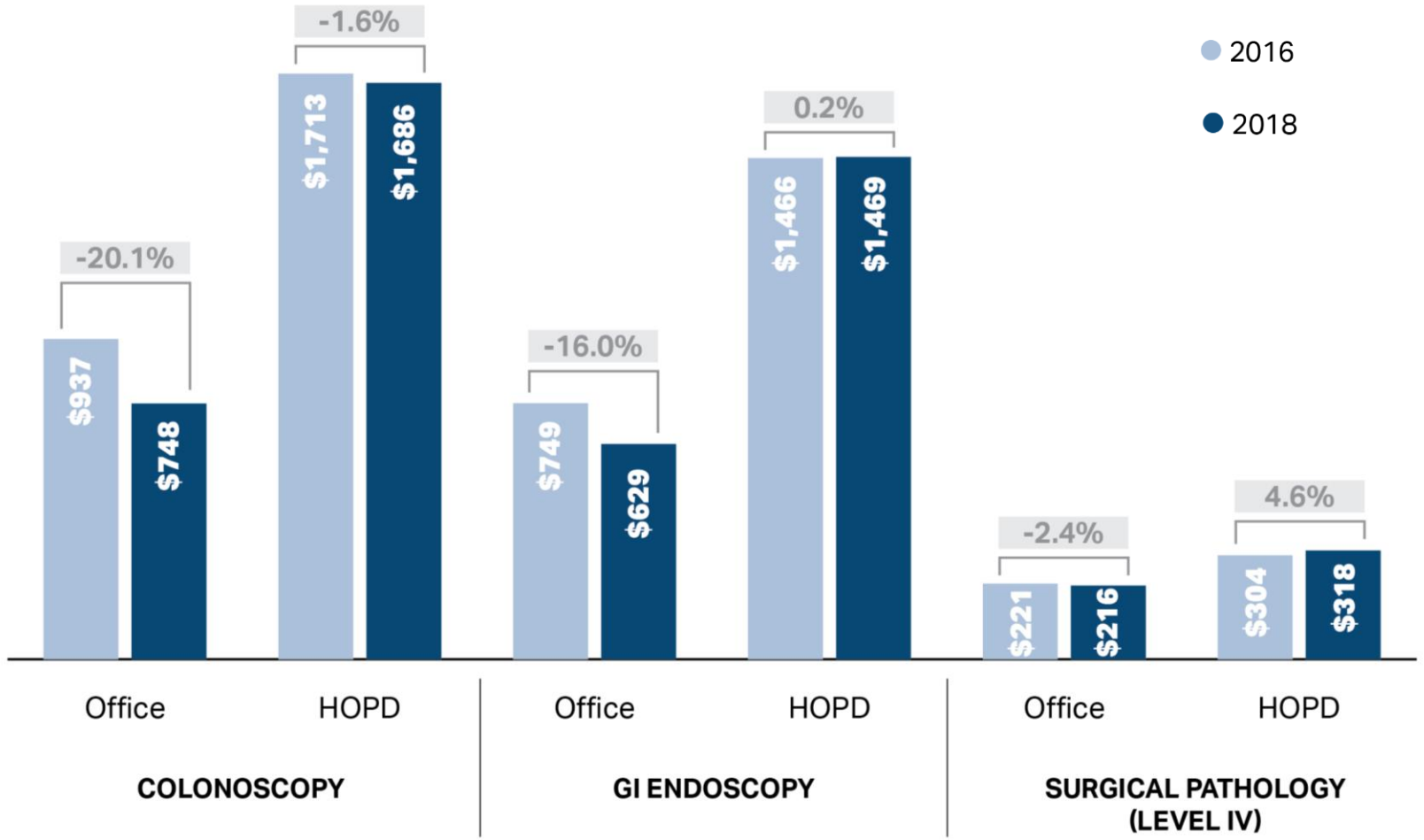
Spending for three common procedures is double if performed in a HOPD versus an office setting in 2018.

Average spending and spending growth for common procedures occurring in both Office and HOPD settings, 2016-2018

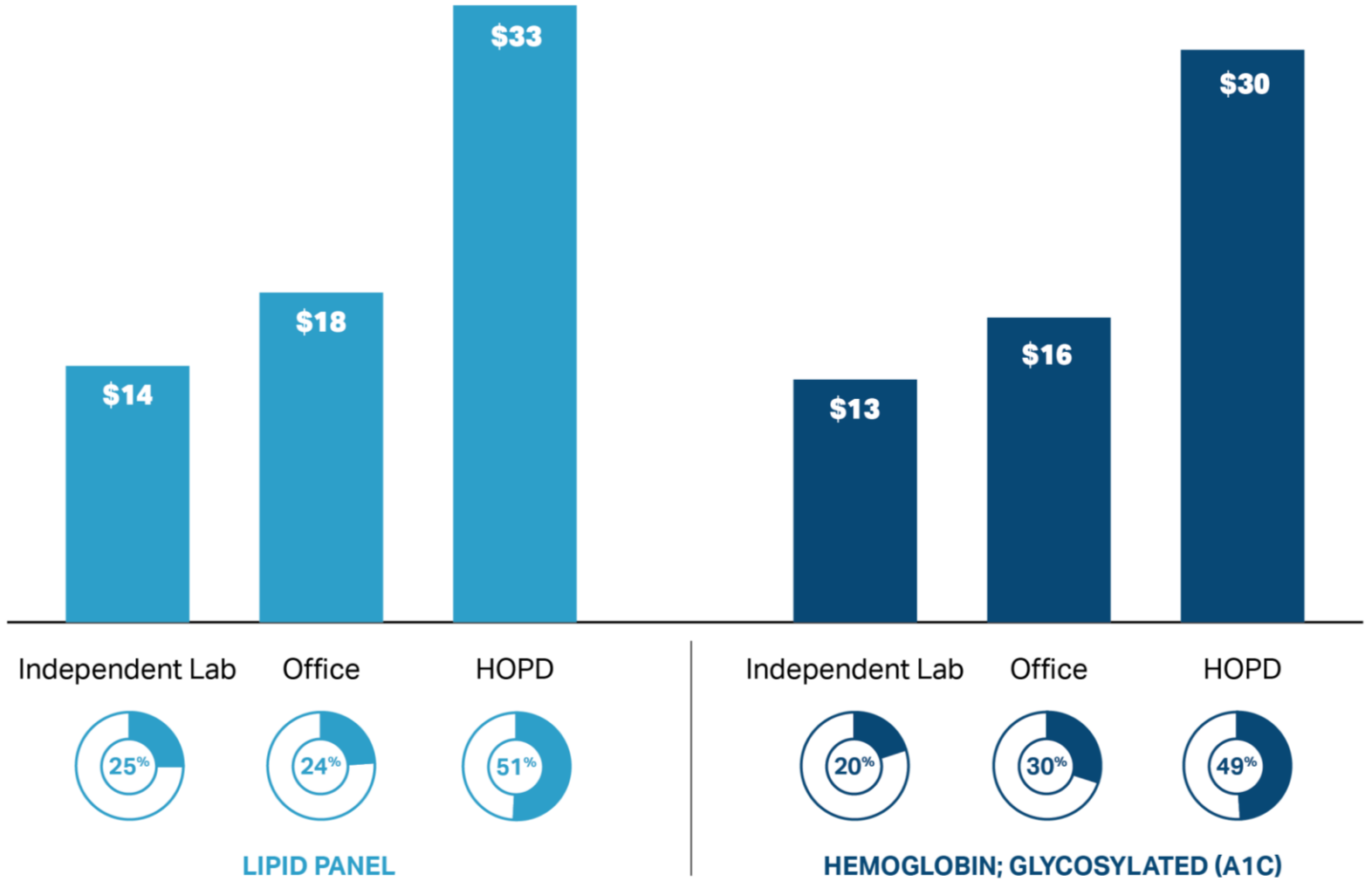


Notes: Services displayed had the highest aggregate HOPD spending in 2018 (colonoscopy: $22.9M; pathology: $20M; endoscopy: $15.6M) and were also billed in 2016. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple'); GI endoscopy (CPT 43239, 'Esophagogastroduodenoscopy'); Surgical pathology (CPT 88305, 'Level IV Surgical pathology, gross and microscopic examination').

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

Half of all common lab tests were performed in a HOPD where prices were double the price of the same labs performed in offices or independent labs.

Average prices for lab services among Independent Lab, Office, and HOPD settings, with volume share, 2018



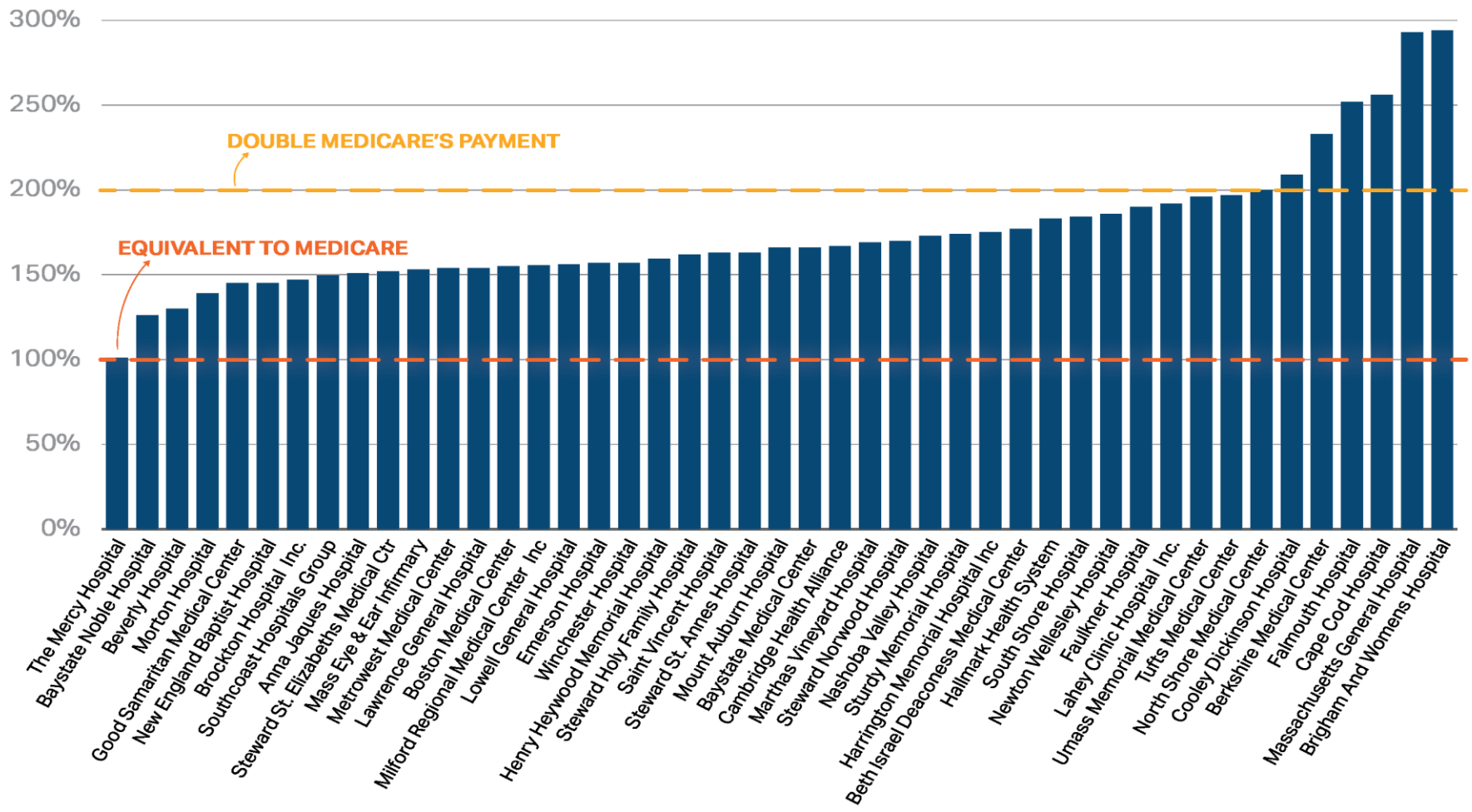
Notes: Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Lipid panel (CPT 80061, 'Lipid panel'); Hemoglobin glycosylated (A1c) (CPT 83036, 'HbA1c'). Share of volume for all ambulatory lab services is listed as a percent under the x-axis; some values may not add up to 100% due to rounding.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Commercial payment rates for hospital outpatient services vary threefold across Massachusetts hospitals, often well exceeding Medicare rates.

Aggregate commercial hospital outpatient payments to hospital relative to what they would have received from Medicare, 2016-2018

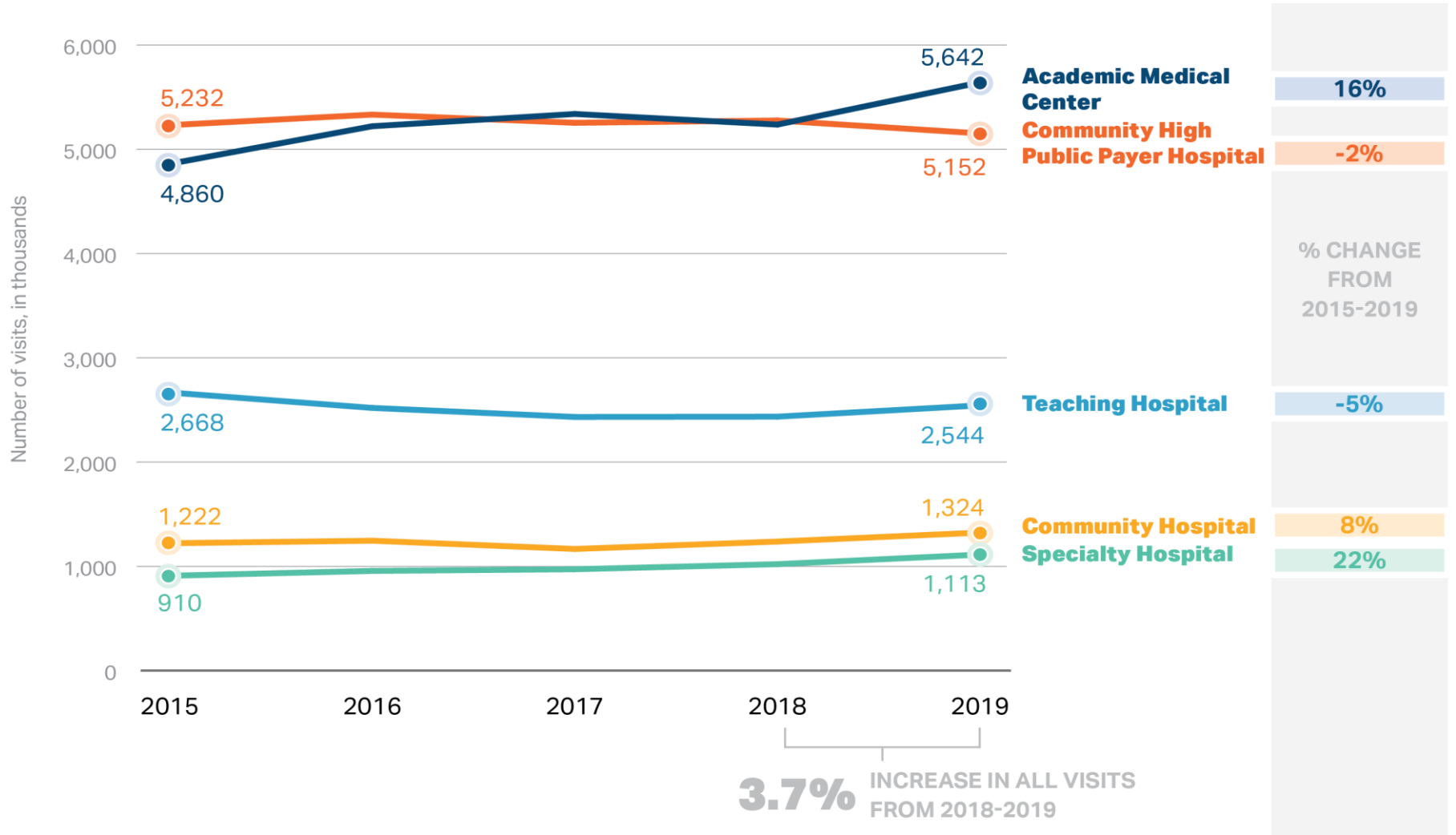


Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate spending from 2016-2018. Analysis based on commercial claims-level data contributed by self-insured employers and private health plans. Authors simulated Medicare payments using 3M software that applied Medicare payment rules to claims data. Data based on more than 100,000 services provided in MA hospitals. Hospitals excluded from figure if fewer than 250 services.

HPC

Increases in visits are also driving hospital outpatient spending growth. In 2019, 71% of the increase in visits occurred at AMCs.

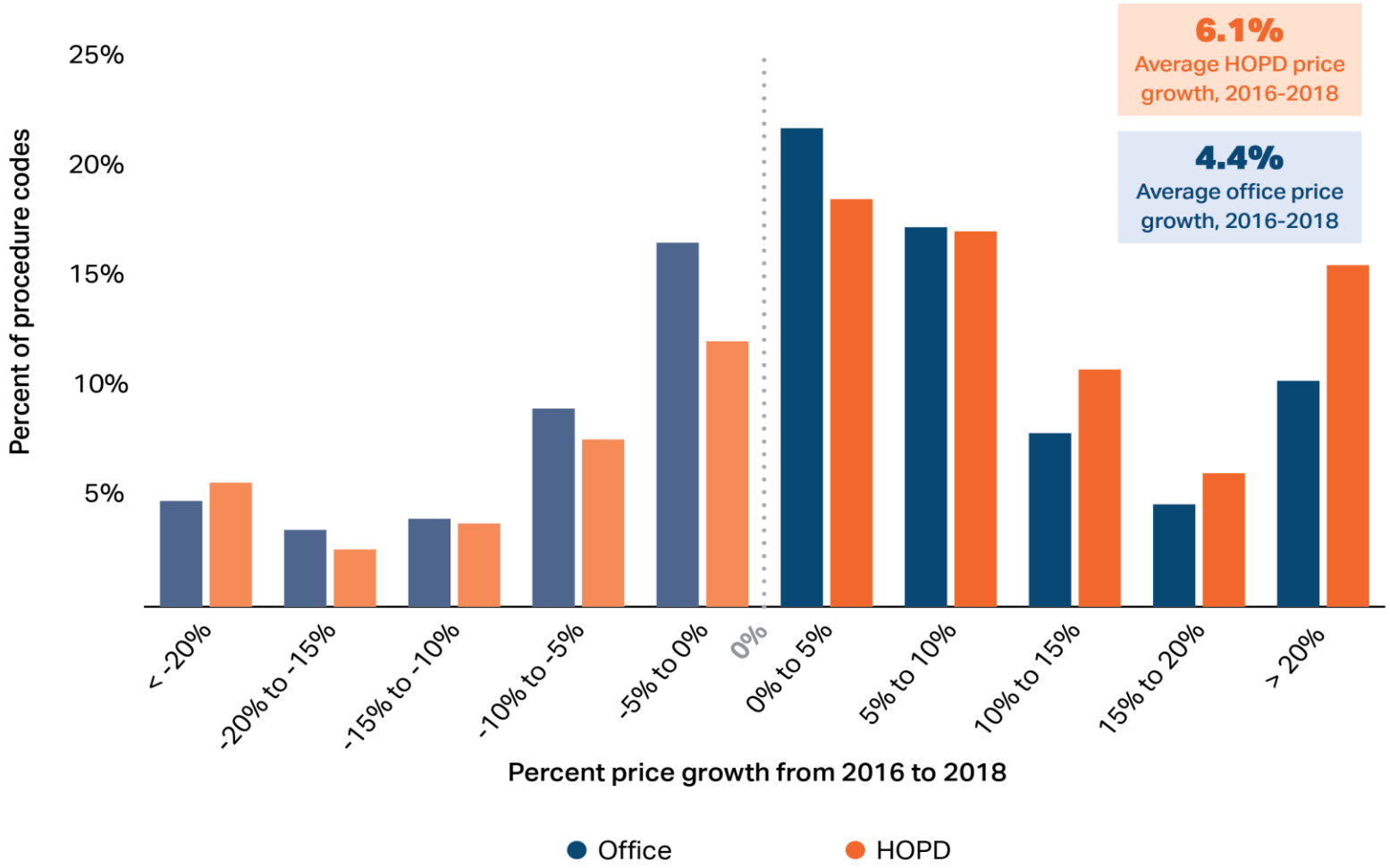
Number of hospital outpatient visits (all payers) by hospital cohort, FY2015-FY2019



Data from the Massachusetts Center for Health Information and Analysis, Acute Hospital Profiles, 2015-9. https://www.chiamass.gov/hospital-profiles/. Outpatient visits are reported by the hospitals.

Prices increased by more than 10% for one in three hospital outpatient department (HOPD) procedures from 2016 to 2018. Average HOPD prices grew 6.1%, versus 4.4% for office procedures.

Percentage of procedure codes occurring in either office or HOPD settings with price changes in the specified range, 2016-2018



Notes: Price growth is computed at the level of the procedure code encounter. Encounters are defined as the same person, same date of service, same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. Procedure codes are consistent between 2016 and 2018, and procedures codes with < 20 services or < $1,000 in aggregate spending in 2018 were excluded. Overall percent price growth for Office and HOPD was weighted by 2018 aggregate spending for the procedure code in the respective setting.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

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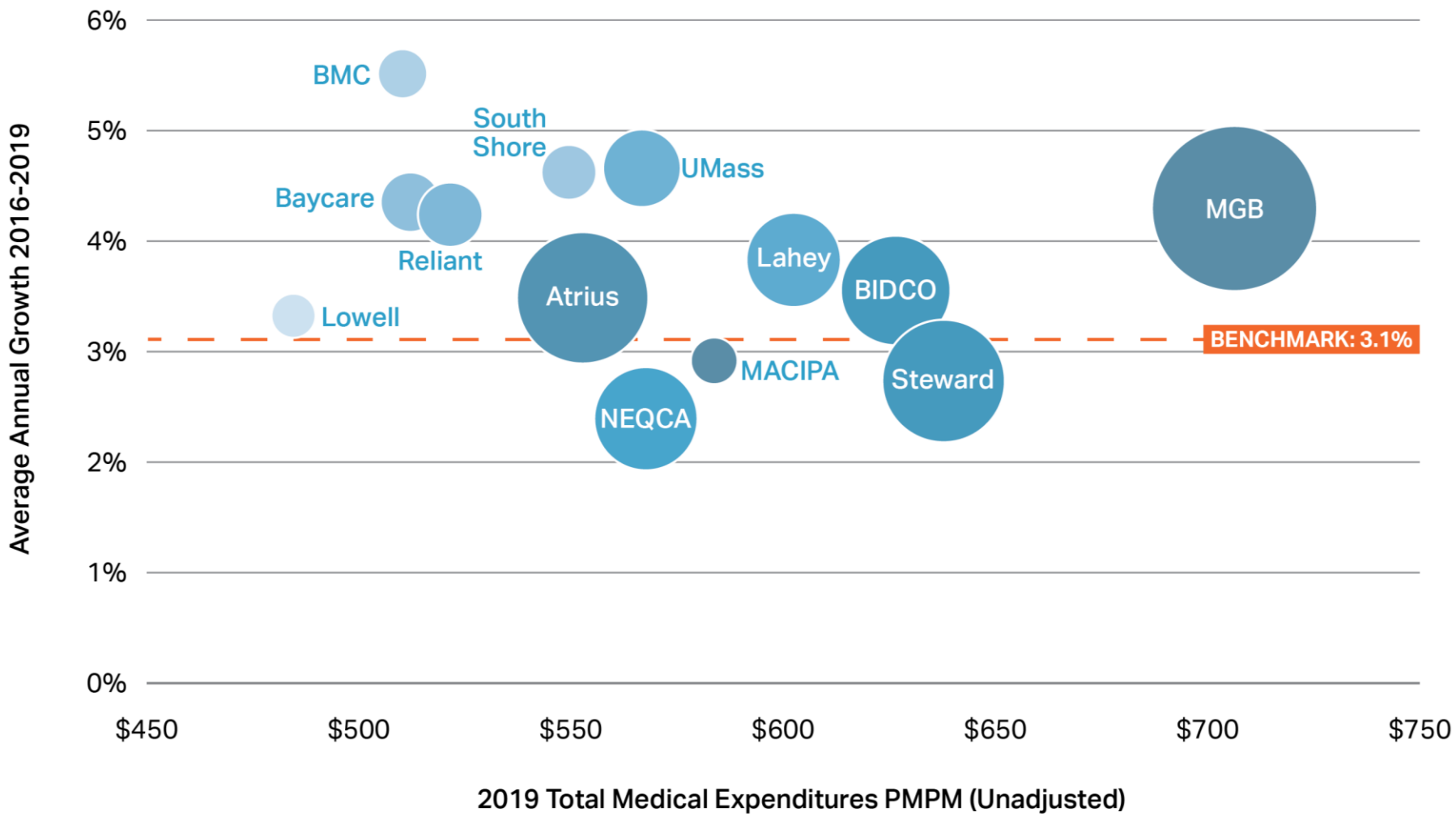
Most provider groups had unadjusted total medical expense (TME) growth over the benchmark from 2016-2019.

Provider group unadjusted TME per member per month in 2019 and 2016-2019 average annual growth in unadjusted TME

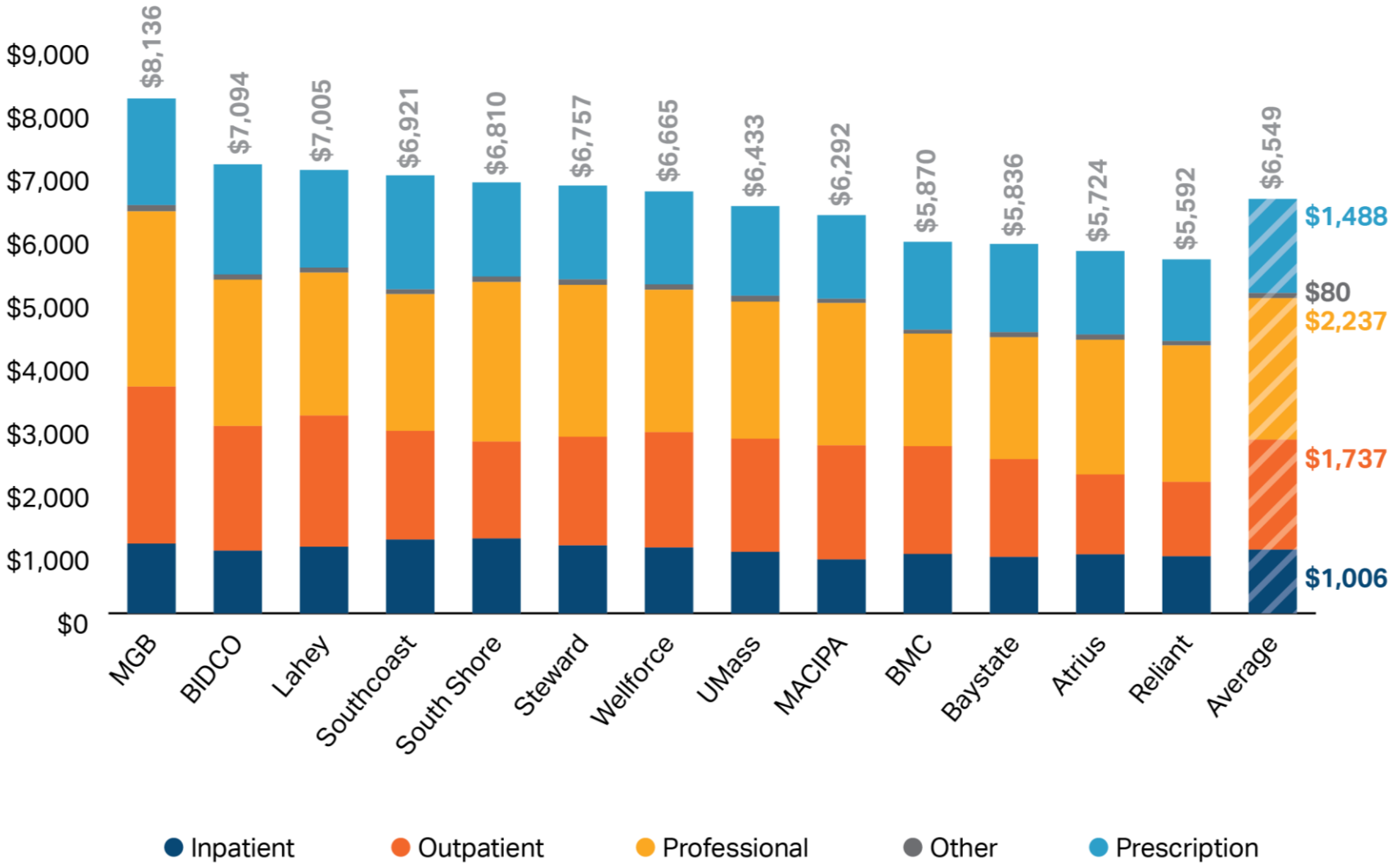


Notes: Bubble size reflect total member months. Only providers with at least 100,000 member months in each year are included. Spending data are for BCBSMA, HPHC and THP only and include PPO plans in addition to HMO and POS. 2019 data is preliminary

Sources: HPC analysis of Center for Health Information and Analysis 2020 and 2019 annual reports; TME databooks.

Unadjusted spending was 45% higher for patients with MGB primary care physicians than for patients with Reliant physicians. Hospital outpatient spending for MGB's patients was more than double that of Reliant.

Unadjusted medical spending per member per year by category and provider organization, 2018



Notes: PMPY: Per member per year. Individuals without 12 months of prescription drug insurance coverage were excluded. Spending results are for commercial attributed adults (N=689,304). See technical appendix for more details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

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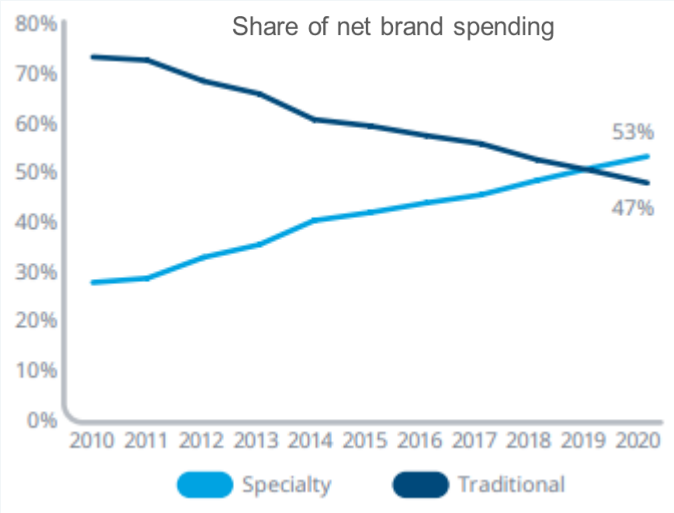
Trends in specialty drug spending in the U.S.

- Specialty drugs – defined by treating complex or rare diseases, special distribution or storage requirements, or high cost – now represent 53% of net brand spending in the U.S., up from 27% in 2010.
- Growth in specialty spending has been largely driven by drugs for **oncology** and **autoimmune** conditions.
  - Net drug spending for these conditions has increased 316% and 402%, respectively, since 2011.
- Biosimilars for three oncology drugs have resulted in significant savings in recent years.



- Expectations for spending growth:
  - ***Factors expected to increase specialty spending growth:*** New product launches are expected to occur at higher levels than in past years, with **an average 50-55 new drugs expected per year from 2021 – 2025**, with large numbers in oncology, immunology, neurology (e.g. Alzheimer's, Parkinson's), and rare disease treatments.
  - ***Factors expected to moderate specialty spending growth:*** The **biosimilar market** continues to mature, with key autoimmune drugs expected to face biosimilar competition in 2023 (Humira) and 2024 (Stelara).

Sources: IQVIA Institute for Human Data Science. The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025. May 2021.

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Over 80,000 commercially-insured Massachusetts residents received at least one of seven low-value care services in 2018 based on APCD analysis.

LOW VALUE SERVICES STUDIED
Screening
T3 (Thyroid) screening for patients with hypothyroidism
Cardiac stress testing for patients with an established diagnosis of ischemic heart disease or angina
Vitamin D screening for patients without chronic conditions
Pre-operative testing
Baseline labs in patients without significant systemic disease undergoing low-risk surgery
Chest radiograph for patients undergoing noncardiothoracic low-risk surgery
Procedures
Spinal injections for lower back pain
Coronary stent for patients with an established diagnosis of ischemic heart disease or angina

80,168

Total # of patients with at least 1 LVC service

137,226

Total # of LVC services identified

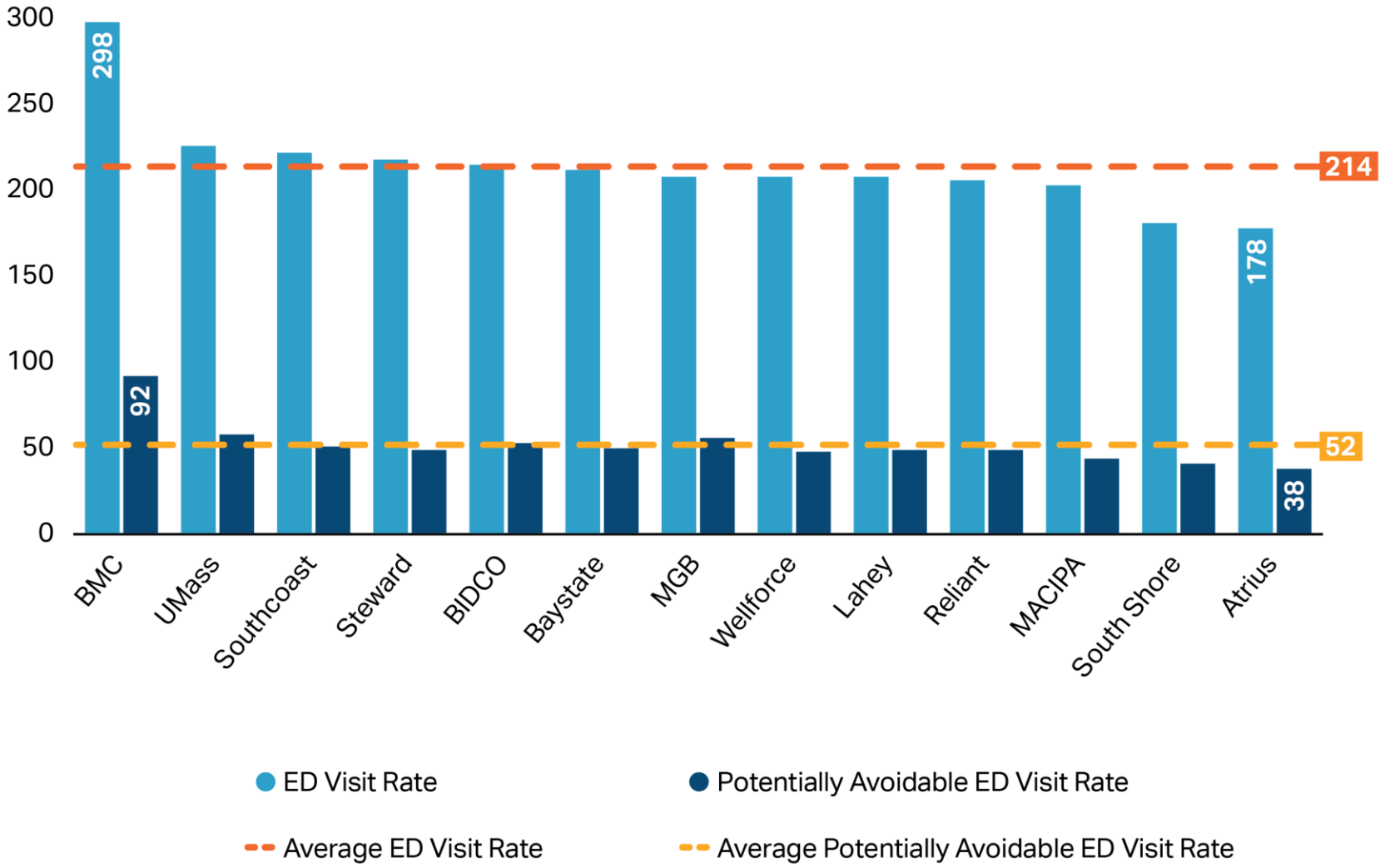
2:1

Variation in LVC spending per 100 eligible members across provider organizations

HPC

Patients with Atrius primary care physicians had the lowest rate of ED and potentially avoidable ED visits in 2018.

Adjusted total and potentially avoidable ED visits per 1,000 attributed commercial patients, 2018

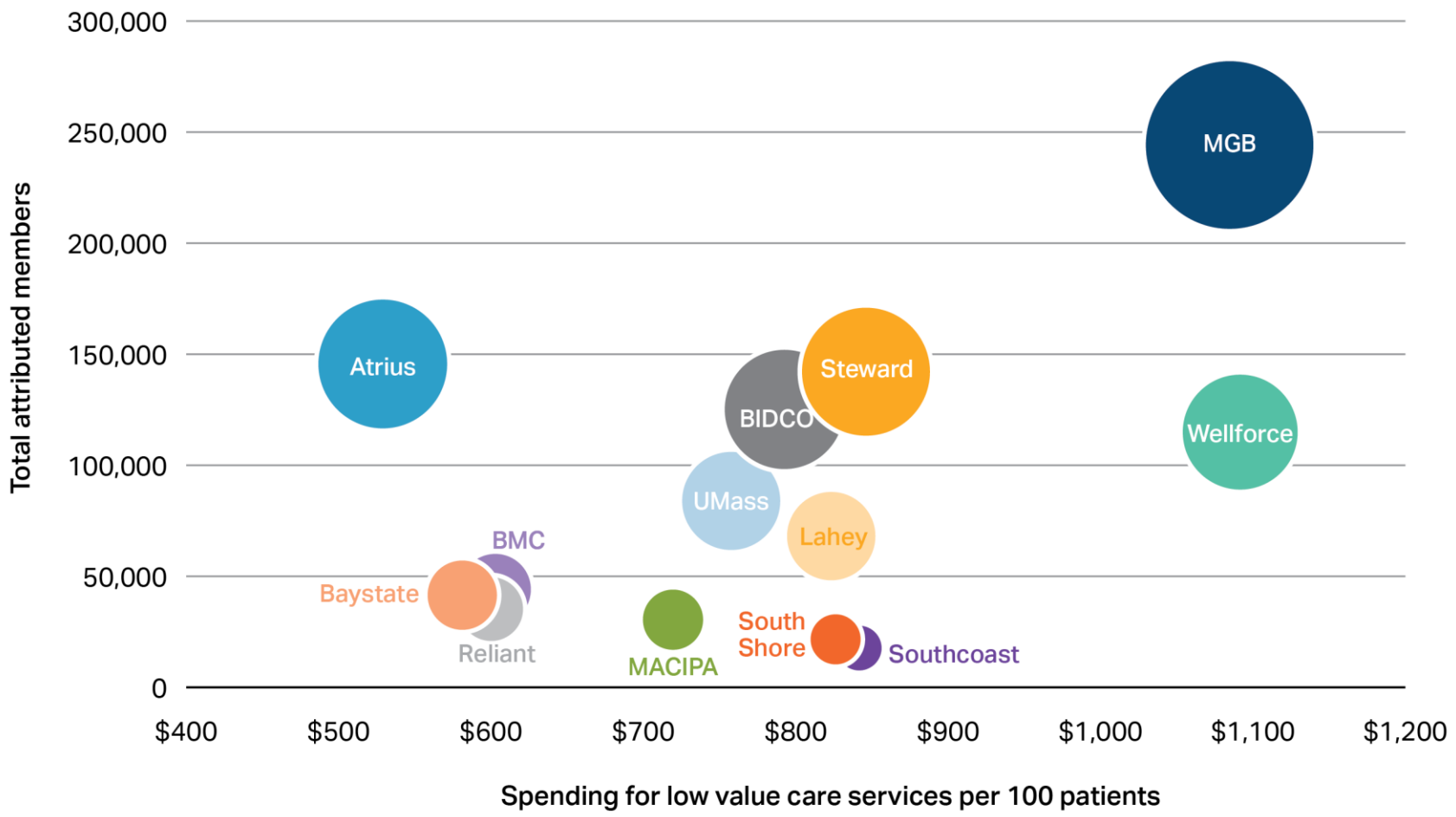


Notes: Potentially avoidable ED visits are based on the Billings algorithm. Results reflect commercial attributed adults, at least 18 years of age (N=877,946). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

Spending for seven low-value services per 100 patients varied by a factor of two across provider organizations in 2018.

Spending for seven low value services per 100 patients and total attributed patients by provider organization, 2018



Notes: Low value spending across all seven measures was summed by provided organization and then divided by the total number of commercial adult attributed patients, and reported as a rate per 100 patients. Results for the low value stent procedure are not presented by provider organization due to small numbers at some organizations in the two previous charts, but are included here in overall spending. Patients included in this population were not restricted to 12 months of continual coverage, N=1,117,933.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

Commission in Recess
10:30-10:40

V. **Health Equity (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Margaret Anshutz, Manager, Healthcare Analytics, GIC

Ray Campbell, Executive Director, Center for Health Information and Analysis

David Seltz, Executive Director, Health Policy Commission

David Auerbach, Senior Director of Research and Cost Trends, Health Policy Commission

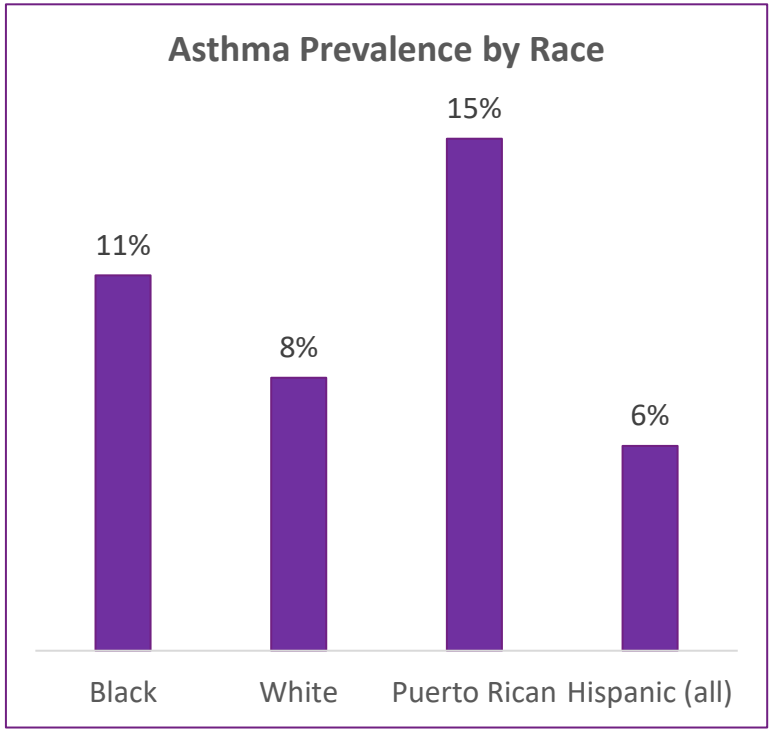
How GIC can make a difference: Targeted interventions

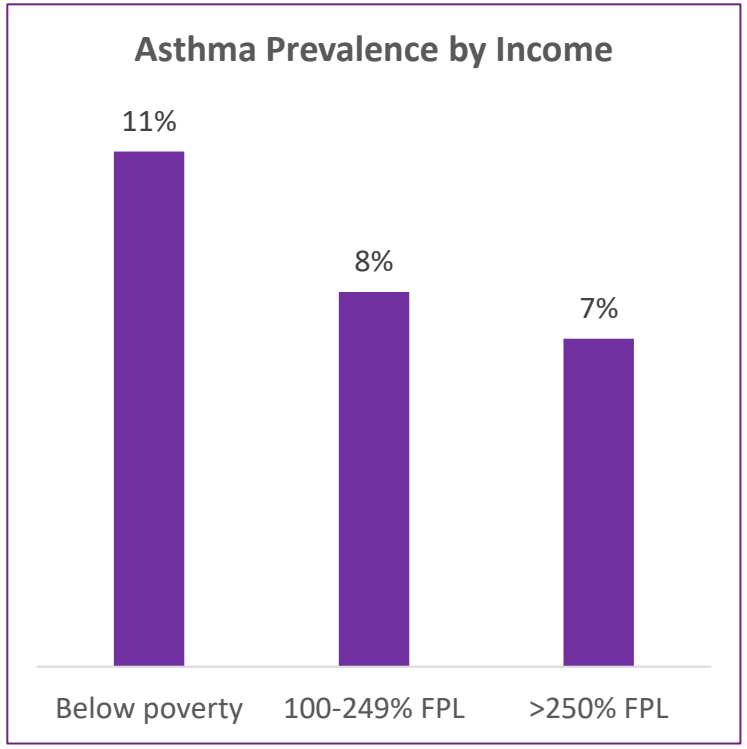
Covered California targeted four conditions that affect large numbers of consumers, have serious potentially avoidable complications, and for which there is strong evidence of racial or ethnic disparities

- Asthma
- Depression
- Diabetes
- Hypertension

Drill down: Asthma

Asthma is highly correlated to both race and income





Potential GIC interventions based on data findings

- Value-based formulary
  - Shown to decrease racial disparities in medication adherence
- Health plan reporting and/or performance guarantees around access and use
- Health plan reporting and/org performance guarantees around blood pressure control
- Public reporting

Source: Asthma Disparities in America, Data 2018 from CDC and National Center for Vital Statistics
FPL= federal poverty level

State-wide alignment for a greater market impact

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- Data standards and definitions
- Imputation methods

- Framework of addressing racism first
- Market-wide policy priorities
- Health equity lens in all matters

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Background on Health Equity and the Imperative for Action

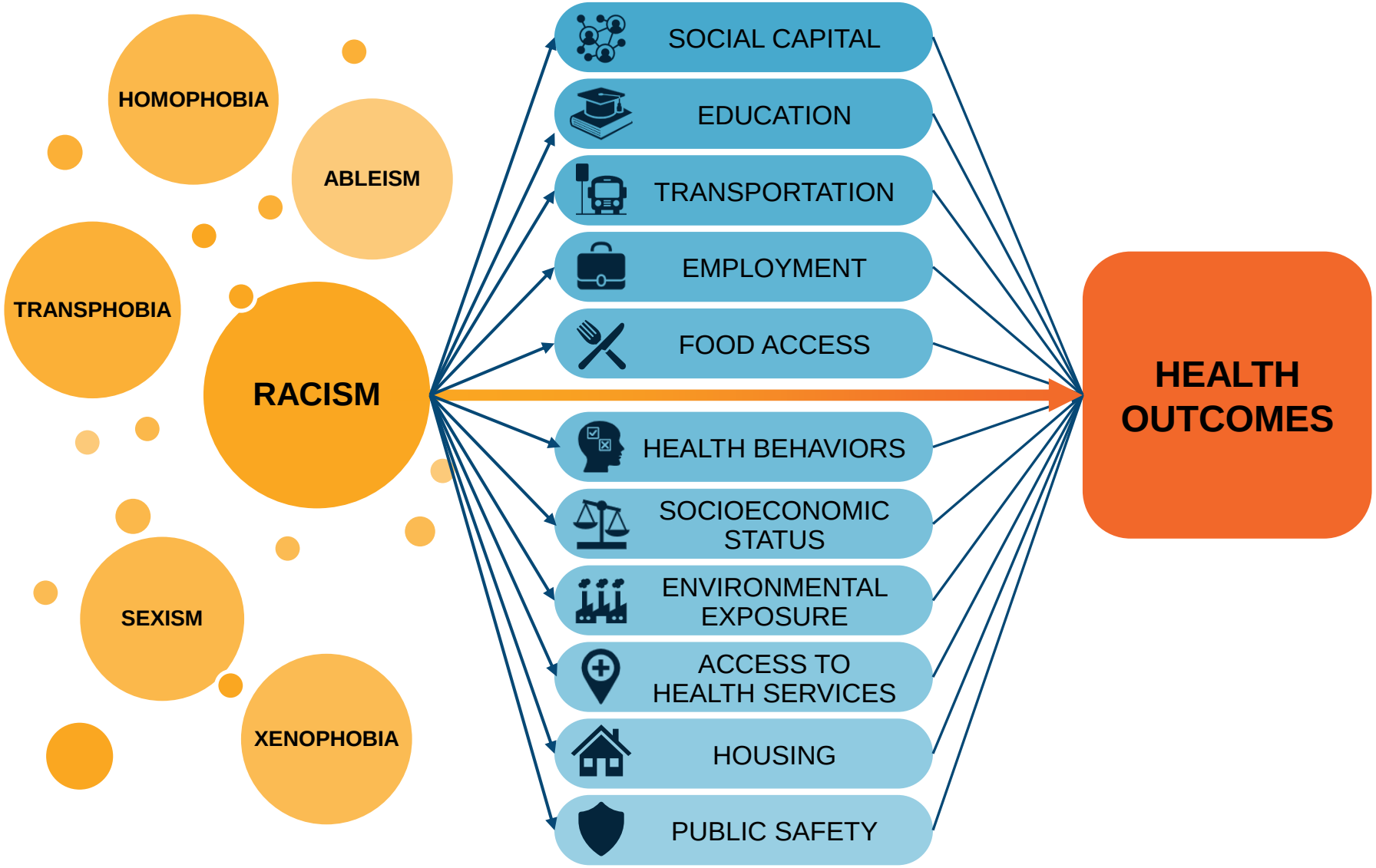
The disparate impact of COVID-19 on communities of color and ongoing injustices of police brutality across the country expose systemic racism and deeply embedded structural inequities.

These inequities are not unique to the health care system but are reflected in persistent health disparities and increased disease burden for communities of color and other marginalized populations. In addition to their impact on health and well-being, these inequities result in higher health care spending and an imbalanced distribution of resources for both individuals and for all people of the Commonwealth of Massachusetts.

Health equity is the opportunity for everyone to attain their full health potential, with no one disadvantaged from achieving this potential due to socioeconomic status or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography).

Health inequities in the Commonwealth have been well documented by the Massachusetts Department of Public Health (DPH), the Center for Health Information and Analysis (CHIA), the Office of the Attorney General, the HPC, and others. The **Office of Health Equity** within DPH works to address social determinants so everyone can attain their full health potential.

Racism, Among Many Structural Inequities, Negatively Impacts Health Outcomes and Other Social Determinants of Health



Source: Boston Public Health Commission's Racial Justice and Health Equity Initiative; available: http://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Documents/RJHEI%202015%20Overview%20FINAL.pdf

The HPC's Commitment to Health Equity

Eliminating Health Inequities is Integral to Achieving the HPC's Mission

*The HPC's mission is to advance a more transparent, accountable, and **equitable** health care system through its independent policy leadership and innovative investment programs. The HPC's overall goal is better health and better care – at a lower cost – **for all residents** across the Commonwealth*

The HPC's statute states that the agency should seek to address health care disparities through its work:

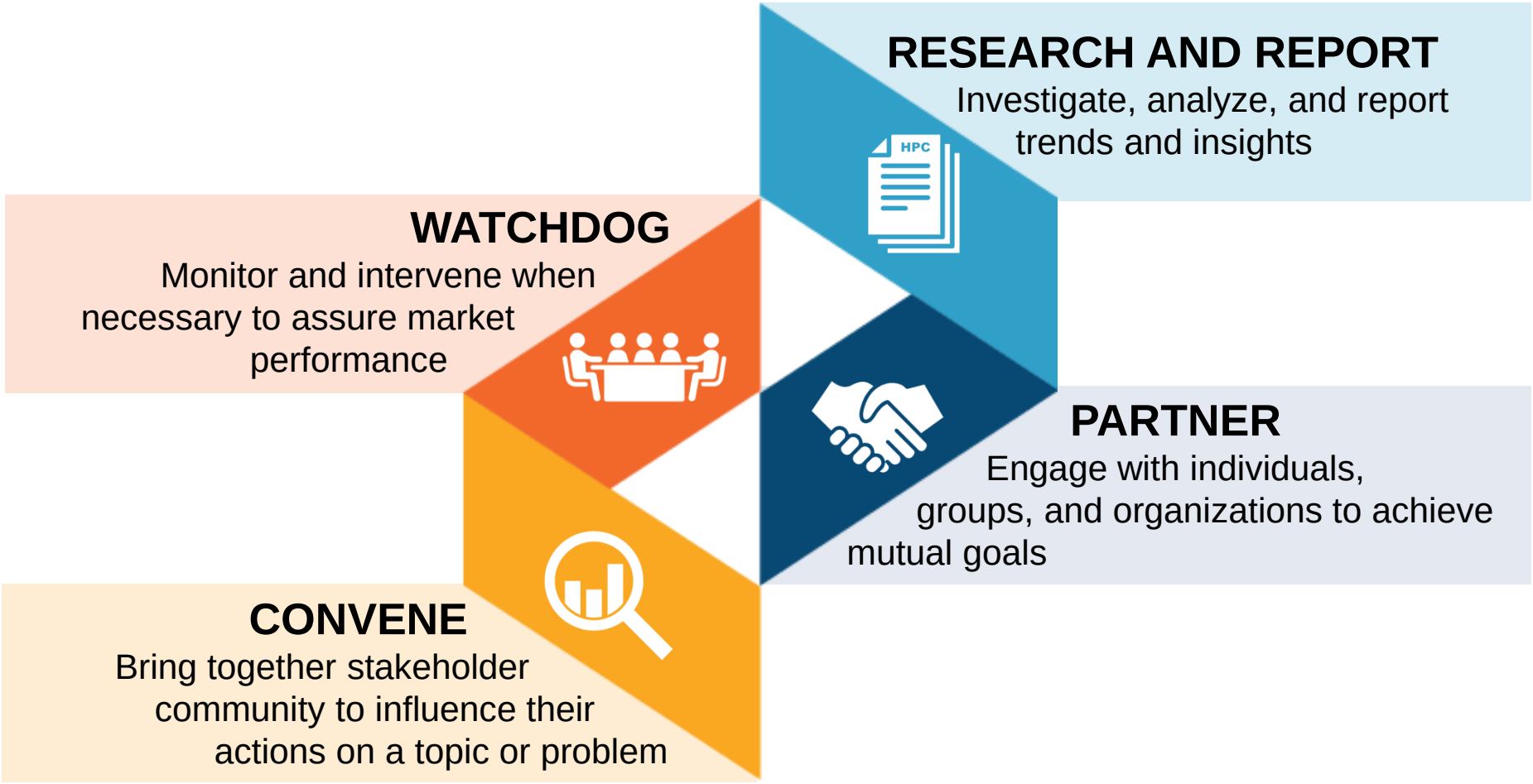
*The commission shall establish goals that are intended to **reduce health care disparities** in racial, ethnic and disabled communities and in doing so shall seek to incorporate the recommendations of the health disparities council and the office of health equity.*

To reflect the HPC's commitment to advance health equity and promote social and economic justice throughout its work, the HPC is proposing an action plan **to ensure that health equity is a core component of the HPC's work today and going forward.**

Principles for Integrating Health Equity into the HPC's Work

- The HPC acknowledges the pervasiveness of health inequities – and the systemic racism that underlies them – and **that eliminating inequities is integral to achieving the HPC's mission** of better health and better care at a lower cost for all residents of the Commonwealth.
- The HPC will **embed health equity concepts** in all aspects of our work and will **apply all four of its core strategies** to the goal of advancing health equity in the Commonwealth: research and report, convene, watchdog, and partner.
- The HPC's work will be **informed and guided by those with lived experience** of inequities.
- The HPC will educate itself about the impact of systemic racism and will **promote diversity, equity, and inclusion in our workplace** in order to more fully cultivate the culture of anti-racism within our agency.
- Advancing health equity in the Commonwealth is a **shared responsibility**. The HPC will actively seek opportunities to align, partner, and support other state agencies, the health care system, and organizations working for health equity on these goals.

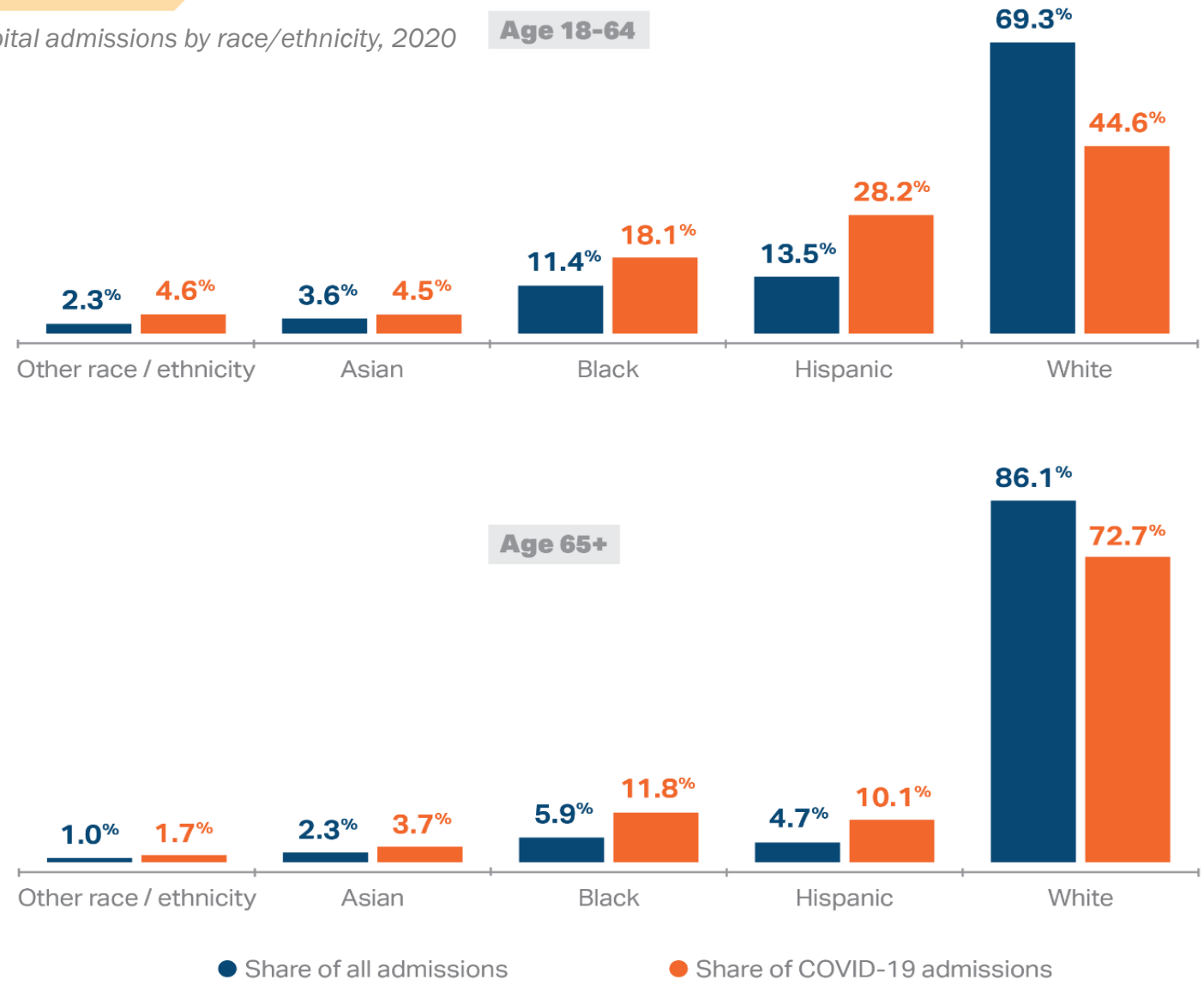
The HPC Will Use All Four of its Core Strategies to Advance Health Equity



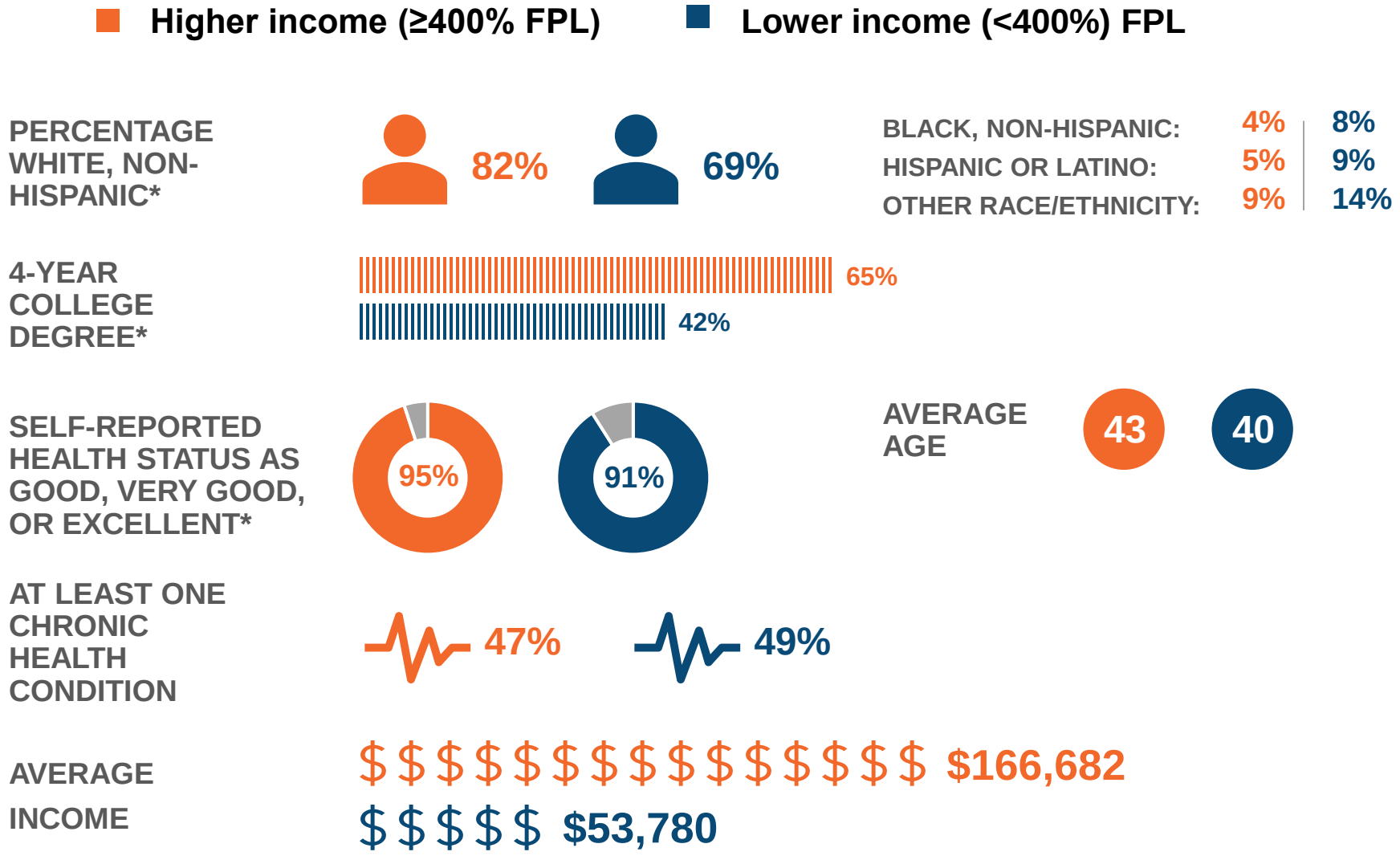
Hispanic and Black patients represented a disproportionate share of COVID-19-related hospital admissions in 2020.

HOSPITAL | INPATIENT

Inpatient hospital admissions by race/ethnicity, 2020



Adults in lower income households were more likely to be people of color and to have less education but report similar health status.

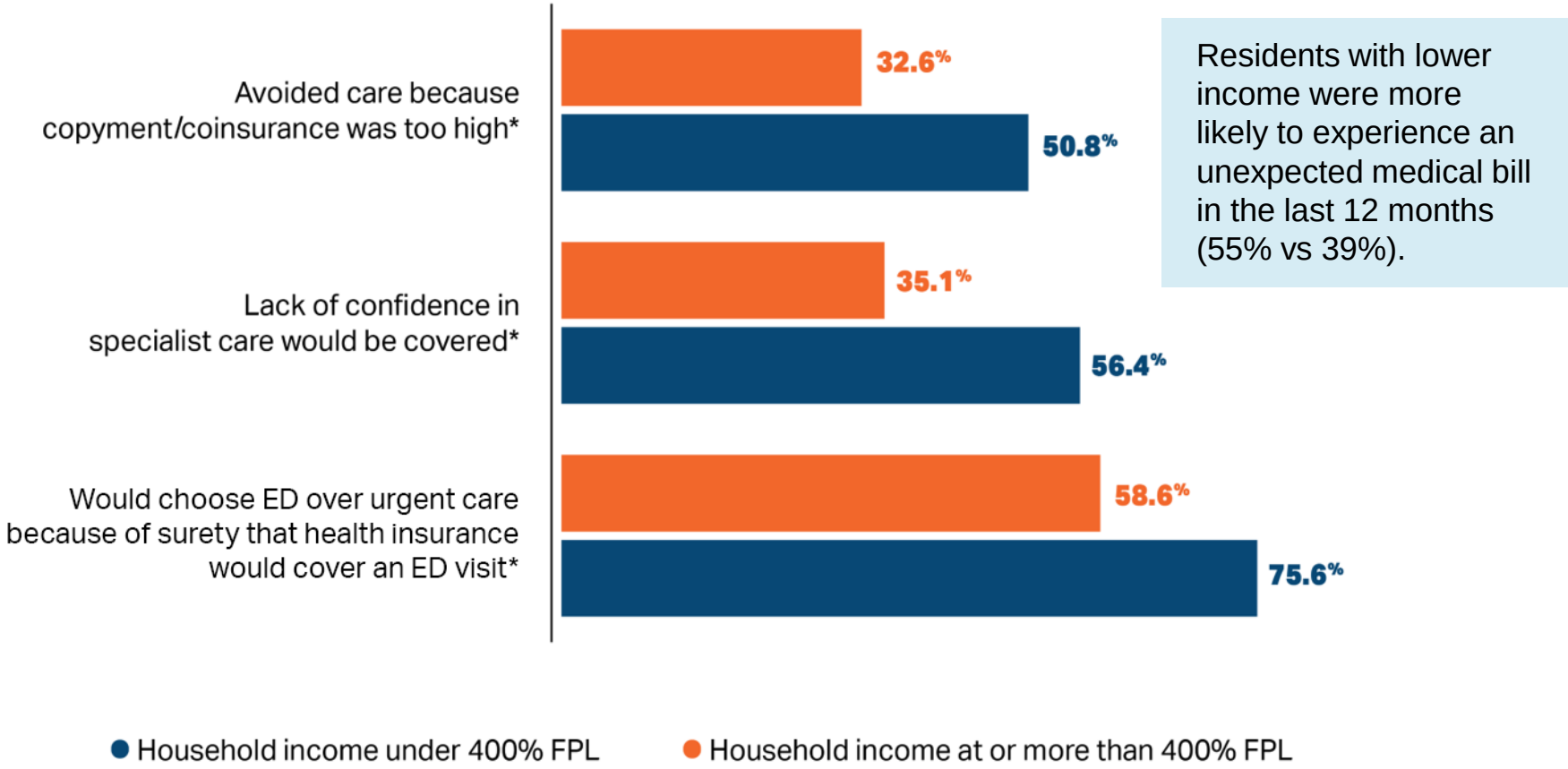


Notes: 400% Federal Poverty Level (FPL) is $103,000 for a family of 4 in Massachusetts. Results are weighted to produce state-level estimates. * indicates significance at P<0.05 level.

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income avoided care because of copays/coinsurance and lack of confidence that needed care would be covered.

Percent of commercially-insured adults who avoided needed care because of cost or lacked confidence in coverage, by household income status, 2019



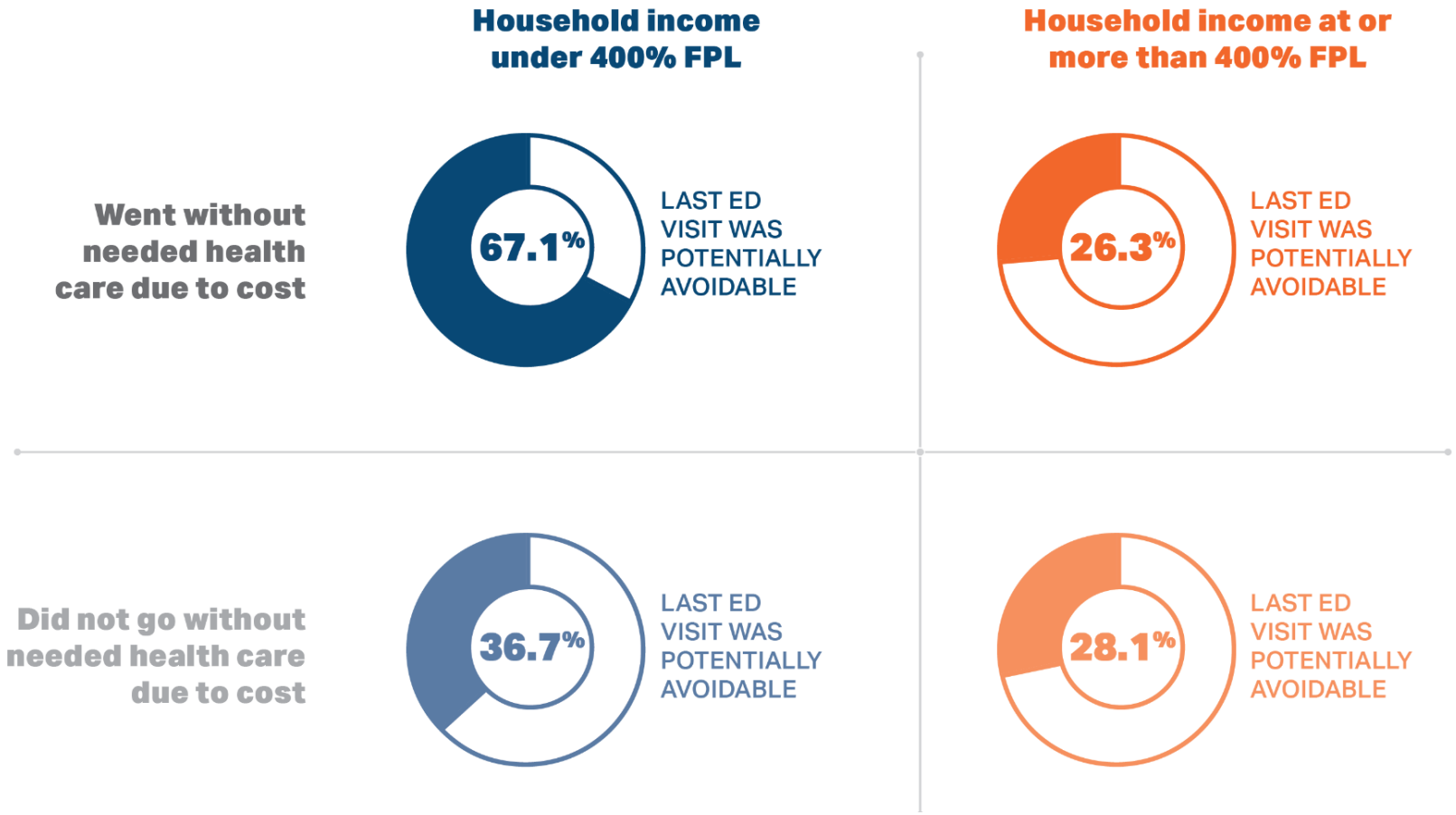
Residents with lower income were more likely to experience an unexpected medical bill in the last 12 months (55% vs 39%).

Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.
Question text: "Would any of these be important reasons for you to choose a hospital emergency room over an urgent care center or retail clinic?" "The last time you went without needed care because of cost was it because of any of the following?" "How confident are you that you know whether or not the following would be covered by your health insurance plan if it was needed?" "In the past 12 months, have you or any of your immediate family members received a medical bill where the health insurance plan paid much less than expected, or did not pay anything at all?"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey and 2019 MHIS Recontact Survey

Those who have lower income and went without needed care due to cost were twice as likely to have had a potentially avoidable ED visit.

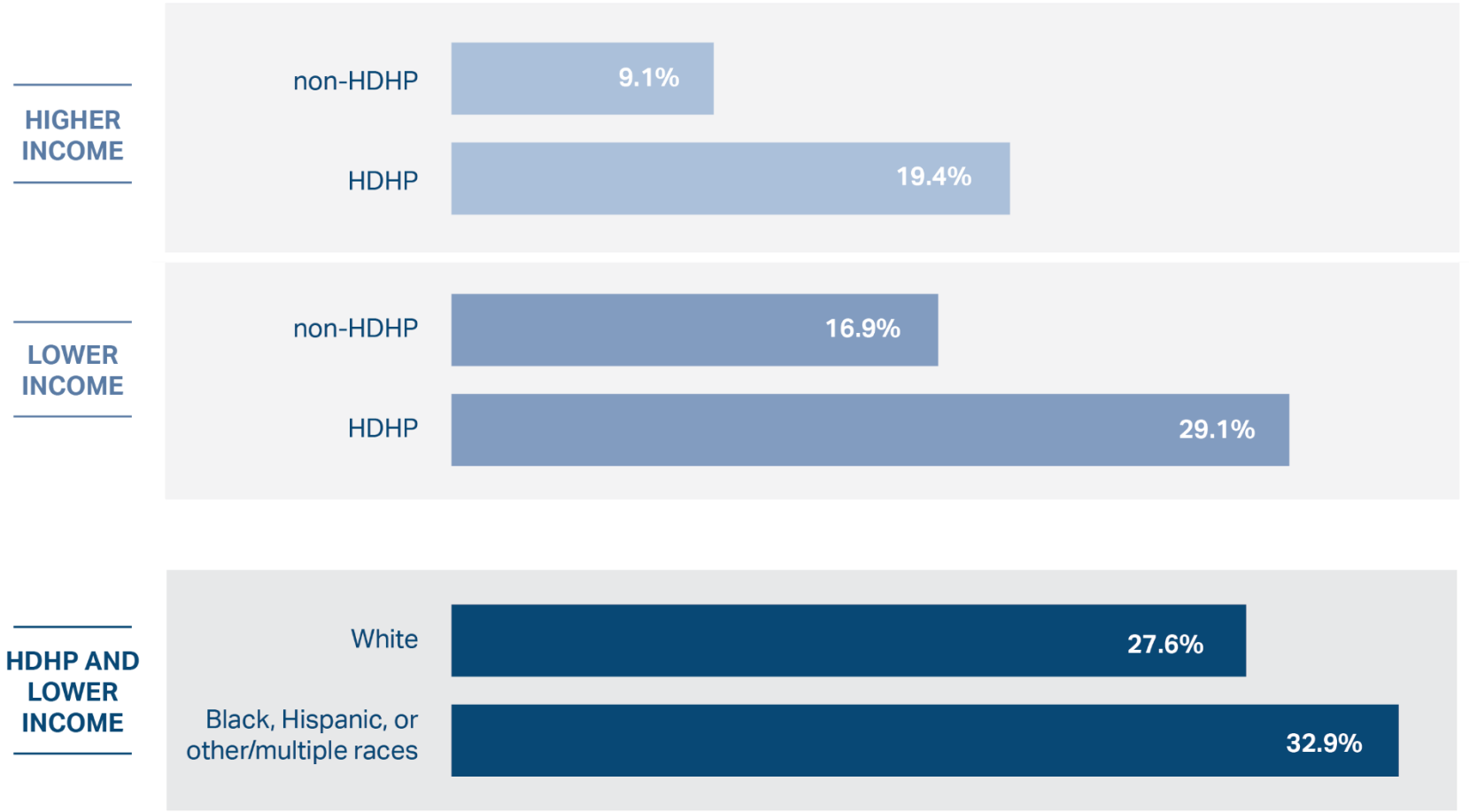
Percent of commercially-insured adults whose last ED visit was potentially avoidable, by household income and unmet health care needs due to cost, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Needed health care includes doctor, specialist, prescription drug, and mental health care. Clockwise from upper left quadrant, estimated number of Massachusetts residents whose last ED visit was potentially avoidable: 32,210/48,031, 18,421/70,097, 89,246/317,376, and 57,464/156,749. Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "…not fill a prescription for medicine needed for you", "… not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed". "The last time you went to a hospital emergency room, was it for a condition that you thought could have been treated by a regular doctor if he or she had been available?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with high deductible plans were also twice as likely to go without needed health care or prescription drugs because of cost.

Percent of commercially-insured Massachusetts adults who said they went without needed doctor care, specialist care, mental health care or prescription drugs, 2019



Notes: 'Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Question text: “Because of cost, did you go without needed ___ care”, where the categories for types of care included those noted above as well as vision care, dental care, medical equipment, or care from an NP, PA or CNM.

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Contact Information

For more information about the Massachusetts Health Policy Commission:

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http://www.mass.gov/hpc

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HPC-INFO@mass.gov

VI. **CFO UPDATE (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- FY22 Trust Fund Authorization Request (VOTE)
- COVID claims update (INFORM)
- FY21 spending to date (INFORM)

Jim Rust, Chief Financial Officer

VII. **FY22 Trust Fund Authorization Request (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- FY22 Trust Fund Authorization Request

Jim Rust, Chief Financial Officer

VII. **FY22 Trust Fund Authorization Request (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- GIC staff annually requests authorization to use funds from the Commission's Employee Trust Fund to supplement the information technology, administrative services and communications budgets.
  - The funds, if needed, are spent on projects reviewed by senior staff and approved by the Executive Director that benefit employees, who are the contributors to the fund.
- Funds are only used when the agency's needs exceed the applicable budget appropriation.
- The Commission has historically supported these requests.
- GIC reports on prior year spending annually. In FY21, the existing administrative budget was sufficient to cover all expenses and the GIC did not spend any funds from the Employee Trust Fund.
- The following slides detail the Trust Fund authorization requests for FY22, which are materially similar to prior year requests.

VII. **FY22 Trust Fund Authorization Request (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

FY 2022 Information Technology Request	FY2021 Budget	FY2022 Budget
Infratructure Support Support For Mission Critical Equipment : Rapid response support for servers, switches, power backups and printers	$7,075	$7,430
Software/Hardware/Supplies Hardware: leased desktop computers, leased laptop computers, printers, cables, keyboards etc. Software: Microsoft and other software licensing for all GIC users Supplies: printer toner and cartridges, scanner cleaning kits, barcode supplies	$140,000	$100,000
Business Continuity Hardware, software, IT equipment needed for business continuity due to disaster, new EOTSS / Administration/ Legislative mandates or other unforeseen circumstances	$80,000	$80,000
Communication Services Virtual Private Network Services (VPN) and wireless data contracts	$40,000	$80,000
MAGIC SYSTEM SUPPORT Additional support for the MAGIC eligibility system and peripheral systems if needed	$100,000	$100,000
Total	**$367,075**	**$367,430**

VII. **FY22 Trust Fund Authorization Request (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Administrative Services	FY2021 Budget	FY2022 Budget
Staff Training and Conferences	$20,000	$20,000
Publications, Memberships, Subscriptions	$40,000	$40,000
Total	$60,000	$60,000

Member Engagement	FY2021 Budget	FY2022 Budget
Video Production	$39,600	$25,000
Website Form Development (ADA Compliance)	$700	$700
GIC Transparency – Annual Report	$7,500	$7,500
Benefits Administration (ADA Compliance, digital)	$7,300	$7,300
Central Reprographics (Coordinator Training Sessions)	$3,775	$3,775
Total	$58,875	$44,275

FY2021 TEMPORARY HELP AUTHORIZATION REQUEST

The GIC requests the continued authorization for the use of up to 10 temporary employees in FY2022. We currently employ one temporary full-time staff while our Agency employees are largely working from home.

VII. FY21 Trust Fund Request (VOTE)

Motion:

That the Commission authorizes the Chief Financial Officer to pay certain GIC expenses from the Trust Funds, as recommended.

- Valerie Sullivan, Chair
- Bobbi Kaplan, Vice-Chair
- William Archibald
- Rebecca Butler
- Elizabeth Chabot
- Adam Chapdelaine
- Edward Tobey Choate
- Christine Clinard
- Tamara P. Davis
- Gerzino Guirand
- Jane Edmonds
- Joseph Gentile
- Eileen P. McAnneny
- Patricia Jennings
- Melissa Murphy-Rodrigues
- Anna Sinaiko
- Timothy D. Sullivan

VII. **FY21 Trust Fund Request (VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- FY21 Retired Municipal Teachers (RMT) Trust Fund Request

Jim Rust, Chief Financial Officer

VII. **FY22 Trust Fund Authorization Request (INFORM & VOTE)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- The GIC requests that the Commission authorize the expenditure of $1,684 from the Retired Municipal Teachers' (RMT) Life Rate Stabilization Reserve (RSR) for the purpose of payment to Hartford Life Insurance Co. This amount represents the governmental share of premiums owed from prior years discovered during the reconciliation process as part of the closeout of the Hartford contract.
  - Metlife will become the life insurance vendor in FY2022
  - This vote is required as it was not part of the FY2021 Trust Fund authorization request

VII. FY21 Trust Fund Request (VOTE)

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Motion:

That the Commission authorizes the expenditure of $1,684 from the Retired Municipal Teachers' (RMT) Life Rate Stabilization Reserve (RSR) for the purpose of payment to Hartford Life Insurance Co.

- Valerie Sullivan, Chair
- Bobbi Kaplan, Vice-Chair
- William Archibald
- Rebecca Butler
- Elizabeth Chabot
- Adam Chapdelaine
- Edward Tobey Choate
- Christine Clinard
- Tamara P. Davis
- Gerzino Guirand
- Jane Edmonds
- Joseph Gentile
- Eileen P. McAnneny
- Patricia Jennings
- Melissa Murphy-Rodrigues
- Anna Sinaiko
- Timothy D. Sullivan

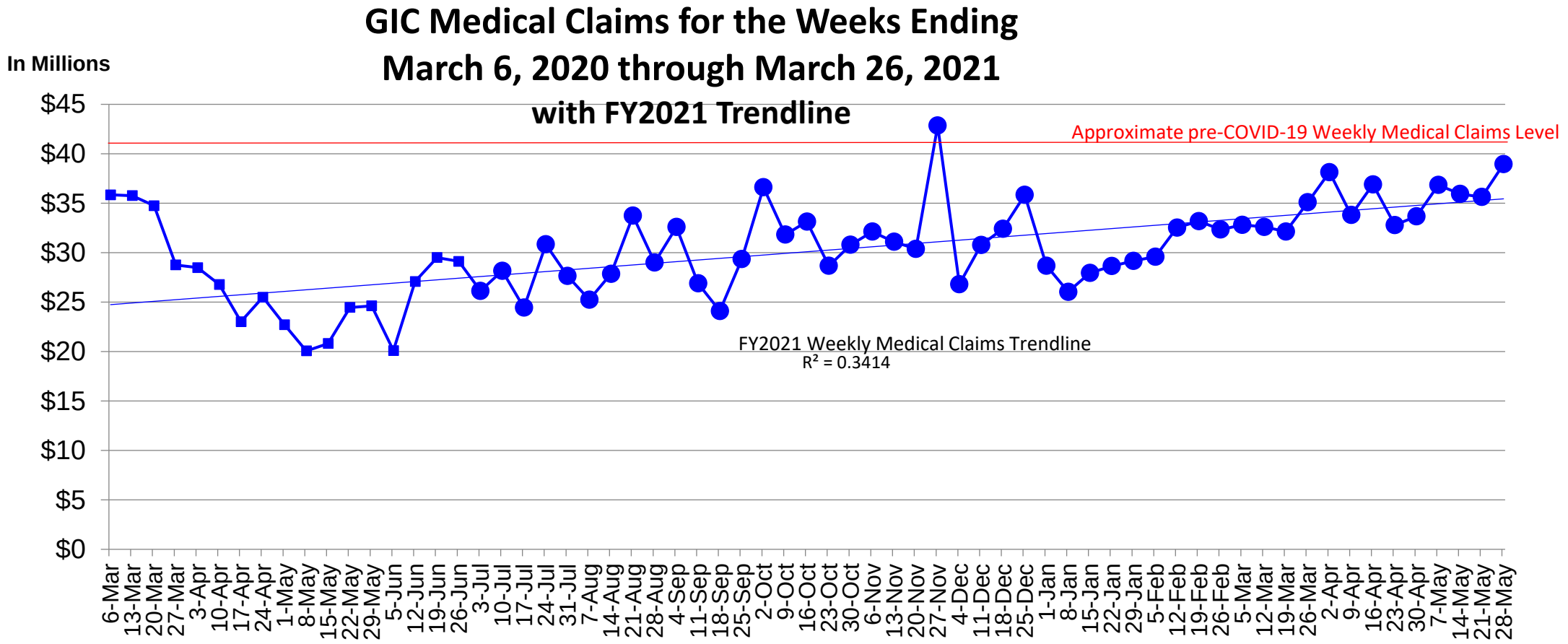
VII. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

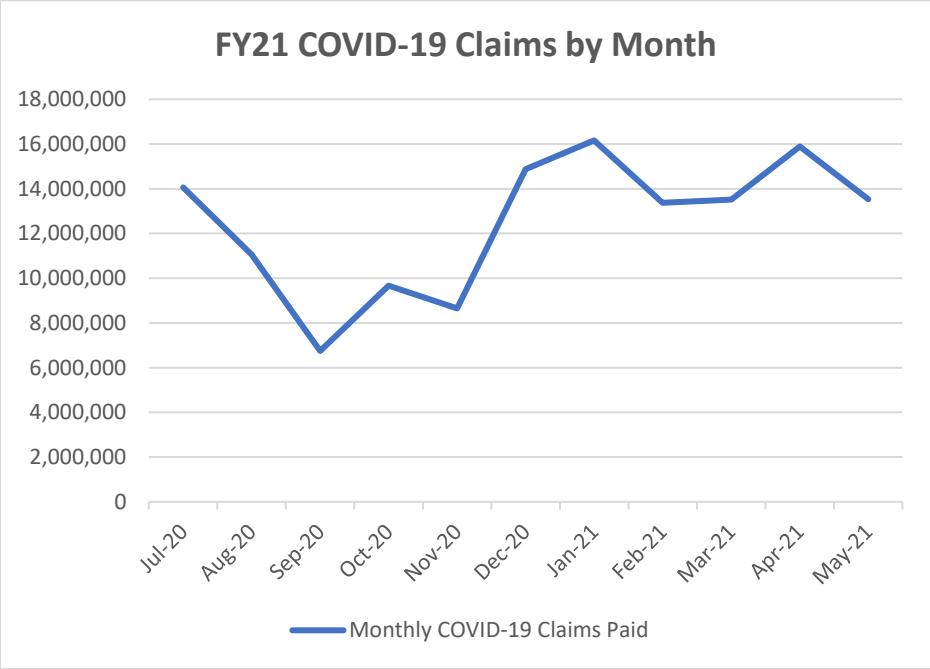
- COVID claims update
- FY21 spending to date

Jim Rust, Chief Financial Officer

VII. **CFO UPDATE (INFORM)**



VII. **CFO UPDATE (INFORM)**



FY21 COVID-19 Claims by Month		
Month	Monthly COVID-19 Claims Paid	FY21 Total
Jul-20	14,059,116	14,059,116
Aug-20	11,050,708	25,109,825
Sep-20	6,748,804	31,858,629
Oct-20	9,671,752	41,530,381
Nov-20	8,650,943	50,181,325
Dec-20	14,874,875	65,056,200
Jan-21	16,159,981	81,216,181
Feb-21	13,367,247	94,583,428
Mar-21	13,509,366	108,092,794
Apr-21	15,892,384	123,985,178
May-21	13,531,180	137,516,358
Total FY21 COVID-19 Claims to Date		137,516,358
Total FY20 COVID-19 Claims		43,361,207
Total COVID-19 Claims FY20 & FY21		180,877,565

- Medical claims (prior slide) continue to recover to “normal” pre COVID-19 levels
- COVID-19 related claims remained steady in May but the overall trend is decreasing
- Both medical and COVID-19 claims were substantial in May

VII. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

FY21 STATE SHARE EXPENSE FOR GIC PREMIUM ACCOUNTS												
	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	TOTAL
Allways Health Claims	$5,812,204	$5,523,873	$6,084,869	$5,304,091	$5,684,934	$7,002,558	$4,369,196	$5,209,681	$8,200,054	$5,689,454	$6,133,097	$65,014,010
Caremark/Express Scripts/SilverScript Claims	$31,063,815	$37,919,658	$60,020,907	-$12,943,392	$2,625,647	$48,866,285	$48,258,477	$39,468,901	$52,137,724	$41,067,071	$53,098,466	$401,583,560
Davis Vision Claims	$25,904	$29,880	$29,661	$20,931	$35,496	$46,593	$28,040	$29,219	$34,008	$36,570	$35,516	$351,818
Fallon Health Claims	$4,873,114	$5,211,090	$4,437,874	$4,404,298	$6,343,601	$4,434,257	$5,282,535	$5,287,038	$6,553,132	$5,786,893	$7,446,034	$60,059,868
Harvard Pilgrim Claims	$30,742,851	$23,793,092	$34,261,639	$25,105,831	$26,918,727	$31,559,498	$24,844,069	$27,999,954	$35,118,838	$28,364,284	$31,059,019	$319,767,801
Health New England Claims	$7,052,990	$7,347,837	$6,081,038	$5,249,524	$6,797,791	$6,946,821	$6,181,896	$6,924,533	$8,354,258	$7,239,241	$9,430,459	$77,606,388
Tufts Navigator Claims	$31,584,329	$24,102,500	$27,224,857	$32,874,775	$27,314,647	$29,905,648	$31,147,804	$29,565,828	$32,800,481	$39,305,597	$29,042,064	$334,868,530
Tufts Spirit and Medicare Complement Claims	$3,400,288	$2,396,931	$2,830,703	$3,561,139	$2,869,780	$2,884,534	$4,582,266	$3,541,821	$4,256,063	$4,980,326	$6,196,740	$41,500,593
Unicare Claims	$43,178,822	$62,769,083	$47,441,478	$55,415,628	$65,927,599	$51,741,290	$43,556,764	$49,287,975	$67,056,106	$54,309,585	$75,007,957	$615,692,286
Other costs	$32,116	$1,342,358	$740,820	$144,433	$789,999	$258,467	$49,532	$436,301	$191,938	$529,223	$303,033	$4,818,221
Claims sub-total	$157,766,432	$170,436,302	$189,153,847	$119,137,259	$145,308,220	$183,645,951	$168,300,580	$167,751,252	$214,702,602	$187,308,244	$217,752,386	$1,921,263,074
Basic Life	$830,652	$831,801	$828,111	$828,290	$827,544	$826,290	$825,235	$824,571	$822,437	$804,050	$821,121	$9,070,102
Optional Life	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
RMT Life	$46,353	$46,288	$46,182	$47,037	$47,243	$47,236	$47,169	$47,107	$47,016	$48,150	$46,849	$516,628
Long-Term Disability	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dental	$718,399	$717,807	$712,364	$712,922	$711,047	$711,108	$715,286	$714,214	$710,997	$712,917	$712,337	$7,849,396
Tufts Medicare Preferred	$669,376	$669,824	$672,766	$678,415	$681,629	$680,491	$904,025	$679,698	$680,687	$679,203	$678,919	$7,675,032
UBH Optum	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$94,384	$102,884	$102,884	$1,191,224
ASO Administrative Fee	$6,778,249	$6,780,846	$6,740,184	$6,721,725	$6,729,457	$6,721,475	$6,709,792	$6,699,122	$6,681,007	$6,680,975	$6,673,007	$73,915,840
Premiums sub-total	$9,154,413	$9,157,950	$9,110,991	$9,099,773	$9,108,303	$9,097,982	$9,312,891	$9,076,095	$9,036,530	$9,028,179	$9,035,117	$100,218,223
TOTAL	$166,920,844	$179,594,252	$198,264,838	$128,237,031	$154,416,523	$192,743,933	$177,613,470	$176,827,347	$223,739,132	$196,336,423.70	$226,787,503	$2,021,481,297

- April and May medical claims continue to reflect a return to pre COVID-19 payment levels

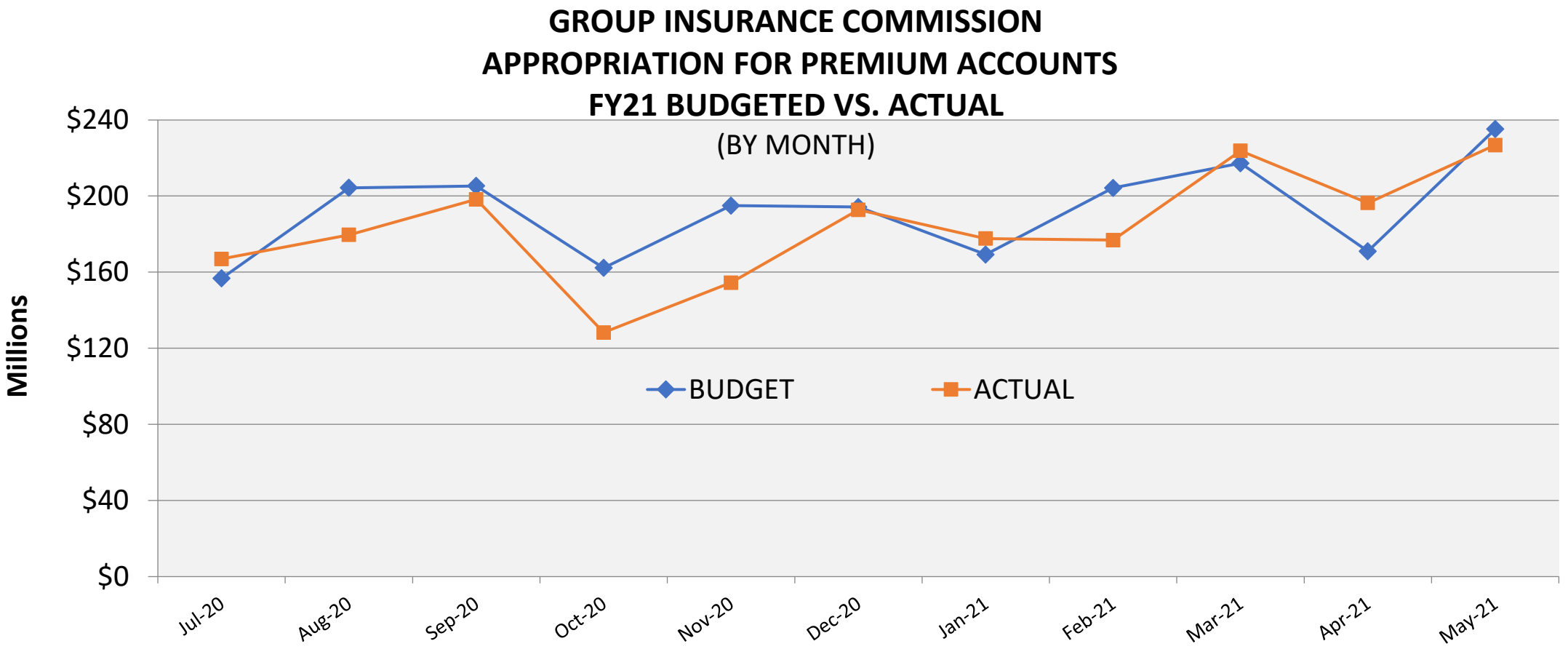
VII. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

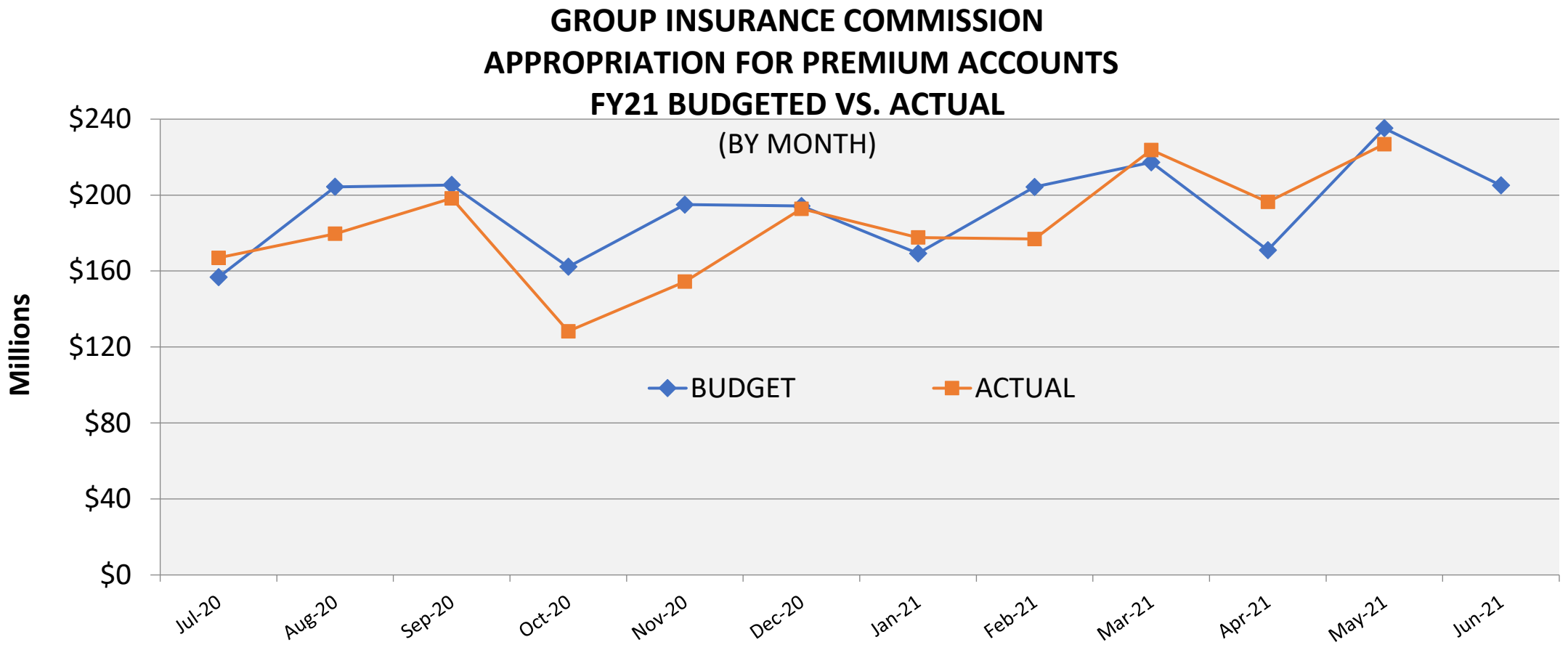
FY21 ENROLLEE SHARE EXPENSE FOR GIC PREMIUM ACCOUNTS												
	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	TOTAL
Allways Health Claims	$1,717,115	$1,627,880	$1,790,465	$1,564,286	$1,676,275	$2,064,195	$1,285,921	$1,530,555	$2,408,997	$1,671,829	$1,805,521	$19,143,040
Caremark/Express Scripts/SilverScript Claims	$8,683,641	$9,037,360	$15,183,128	-$3,322,304	$2,372,081	$12,850,448	$11,931,720	$11,009,213	$13,865,281	$9,783,548	$14,650,436	$106,044,551
Davis Vision Claims	$4,571	$5,273	$5,234	$3,694	$6,264	$7,747	$4,948	$5,156	$6,002	$6,453	$6,268	$61,611
Fallon Health Claims	$1,405,709	$1,495,825	$1,270,102	$1,263,811	$1,818,678	$1,274,024	$1,520,606	$1,512,020	$1,883,808	$1,663,026	$2,137,090	$17,244,701
Harvard Pilgrim Claims	$8,316,735	$6,416,445	$9,241,658	$6,783,791	$7,282,417	$8,530,620	$6,722,870	$7,534,530	$9,461,179	$7,666,093	$8,398,866	$86,355,203
Health New England Claims	$2,018,128	$2,108,219	$1,737,178	$1,505,632	$1,946,876	$1,999,124	$1,770,679	$1,975,106	$2,395,685	$2,076,952	$2,705,285	$22,238,864
Tufts Navigator Claims	$8,713,332	$6,645,911	$7,502,479	$9,065,923	$7,546,087	$8,270,295	$8,608,297	$8,168,931	$9,067,615	$10,869,481	$8,036,761	$92,495,111
Tufts Spirit and Medicare Complement Claims	$940,775	$654,583	$763,999	$977,073	$784,251	$800,608	$1,258,119	$940,438	$1,169,239	$1,362,354	$1,547,377	$11,198,816
Unicare Claims	$11,914,772	$17,362,123	$13,077,091	$15,305,568	$18,267,787	$14,339,794	$12,082,648	$13,389,364	$18,495,985	$15,051,489	$20,847,190	$170,133,810
Other costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Claims sub-total	$43,714,779	$45,353,620	$50,571,334	$33,147,473	$41,700,717	$50,136,855	$45,185,808	$46,065,312	$58,753,791	$50,151,226	$60,134,793	$524,915,708
Basic Life	$224,883	$225,060	$223,751	$223,923	$223,961	$223,603	$223,358	$223,229	$222,750	$217,061	$222,642	$2,454,222
Optional Life	$3,923,235	$3,923,170	$3,925,204	$3,953,910	$3,960,605	$3,969,662	$3,984,265	$3,999,698	$3,989,860	$3,746,275	$4,009,744	$43,385,629
RMT Life	$11,636	$11,620	$11,593	$11,808	$11,859	$11,858	$11,842	$11,825	$11,802	$11,398	$11,760	$129,000
Long-Term Disability	$1,251,801	$1,249,859	$1,246,794	$1,247,604	$1,248,771	$1,247,192	$1,247,090	$1,245,816	$1,242,043	$1,242,768	$1,244,439	$13,714,177
Dental	$2,040,398	$2,048,286	$2,051,202	$2,067,762	$2,073,721	$2,078,821	$2,081,950	$2,086,245	$2,091,958	$2,095,797	$2,096,633	$22,812,773
Tufts Medicare Preferred	$137,007	$137,268	$138,055	$139,328	$140,196	$139,914	$186,758	$139,997	$140,428	$140,315	$140,421	$1,579,686
UBH Optum	$19,656	$19,656	$19,656	$19,656	$19,656	$19,656	$19,656	$19,656	$16,656	$18,156	$18,156	$210,216
ASO Administrative Fee	$1,840,273	$1,840,081	$1,827,160	$1,823,898	$1,828,865	$1,827,236	$1,823,328	$1,820,504	$1,816,395	$1,816,917	$1,815,777	$20,080,433
Premiums sub-total	$9,448,890	$9,455,000	$9,443,415	$9,487,889	$9,507,634	$9,517,943	$9,578,247	$9,546,971	$9,531,892	$9,288,686	$9,559,571	$104,366,136
TOTAL	$53,163,668	$54,808,620	$60,014,748	$42,635,362	$51,208,350	$59,654,799	$54,764,055	$55,612,283	$68,285,683	$59,439,912	$69,694,364	$629,281,843

- As expected, enrollee share paid claims have an identical pattern

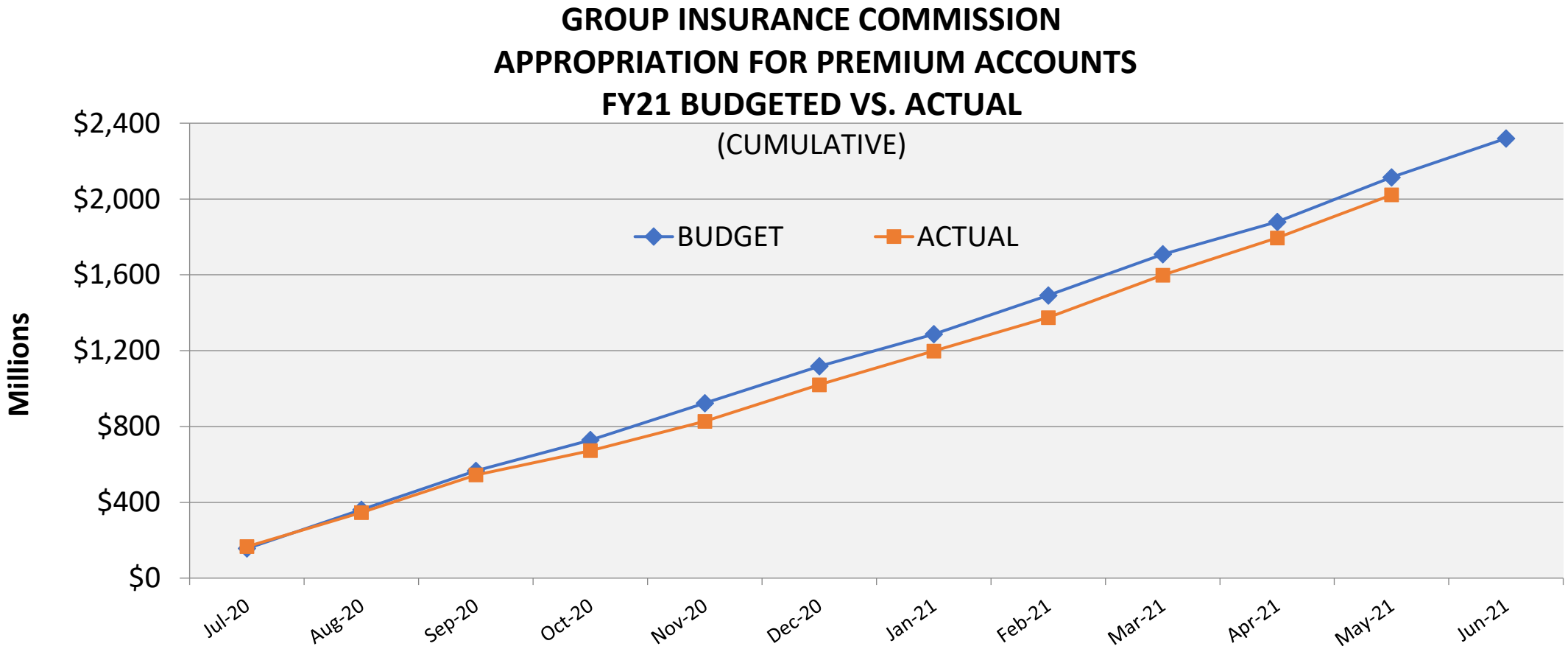
VII. **CFO UPDATE (INFORM)**



VII. **CFO UPDATE (INFORM)**



VII. **CFO UPDATE (INFORM)**



VII. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts Group Insurance Commission
Your Benefits Connection

FY21 STATE SHARE PREMIUM BUDGET FOR GIC PREMIUM ACCOUNTS AS OF MAY 31, 2021				
	BUDGET	EXPENSES	Under Budget / (Over Budget)	% VAR
Basic Life & Health Account #1108-5200 & #1599-6152	$2,105,761,932	$2,013,280,083	$92,481,849	4.4%
Active Dental & Vision Benefits * Account #1108-5500	$8,857,186	$8,201,214	$655,972	7.4%
Total State Share YTD	$2,114,619,118	$2,021,481,297	$93,137,821	4.4%

- Year-to-date Budget performance is largely driven primarily by lower than expected utilization
- The pattern to date reflects the increase in Covid-19 cases at the end of CY 20 and related restrictions
  - March, April, and May 2021 have seen a return to more normal levels
- The majority of GIC spending is in the accounts that provide health insurance and basic life for state and municipal enrollees

VII. Annual Enrollment **(INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

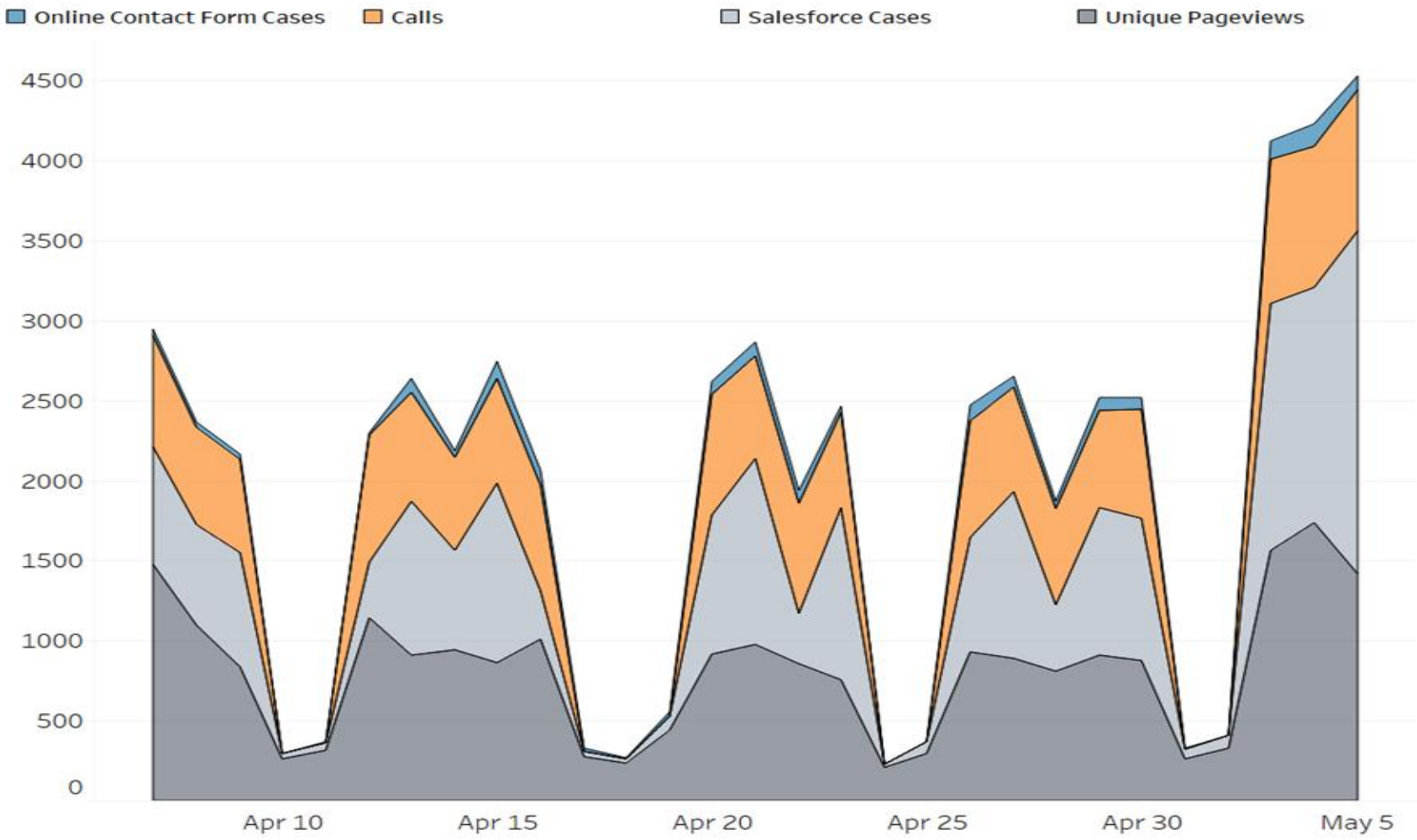
Paul Murphy, Director Operations

&

Cameron McBean, Manager,
Health & Ancillary Benefits

2021 Annual Enrollment Member Touchpoints

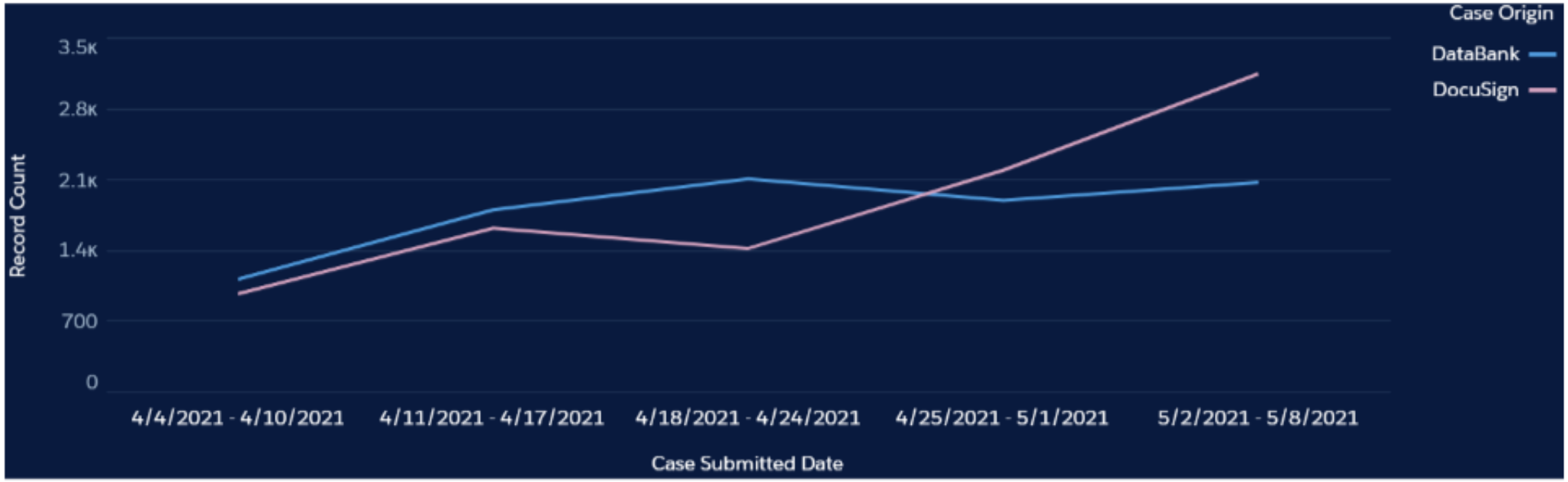
- The GIC received 1,514 online contact form inquiries, 13,858 calls, 18,442 Salesforce cases, and 23,517 unique website pageviews
- The GIC health insurance carriers also handled 14,508 calls



2021 Annual Enrollment Member Touchpoints

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- DocuSign cases (9,398) outpaced DataBank cases (9,039) during Annual enrollment
- 68% of DocuSign cases were submitted for processing within 2 hours.



MAGIC
Group Insurance Commission

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Annual Enrollment Change Report

Coverage Start Date: 7/1/2021

Coverage	New Insured	Transfers To	Total	Terminated	Transfers From	Total	Gain Or Loss
ALLWAYS HEALTH PARTNERS	119	101	220	60	168	228	-8
FALLON DIRECT CARE	55	28	83	27	156	183	-100
FALLON SELECT	39	60	99	18	80	98	1
HARVARD PILGRIM INDEPENDENCE	148	196	344	50	242	292	52
HARVARD PILGRIM MEDICARE ENHANCE	31	64	95	14	27	41	54
HARVARD PILGRIM PRIMARY CHOICE	191	108	299	55	255	310	-11
HEALTH NEW ENG	206	86	292	58	108	166	126
HEALTH NEW ENG MEDICARE SUPPLEMENT PLUS	7	11	18	10	8	18	0
TUFTS MEDICARE COMPLEMENT	33	87	120	16	37	53	67
TUFTS MEDICARE PREFERRED	9	14	22	7	56	63	-41
TUFTS NAVIGATOR	375	337	712	131	445	576	136
TUFTS SPIRIT	144	80	224	46	222	268	-44
UNICARE BASIC w/ CIC	128	356	484	54	247	301	183
UNICARE BASIC w/o CIC	16	62	78	3	33	36	42
UNICARE COMMUNITY CHOICE	246	299	545	95	374	469	76
UNICARE MEDICARE EXTENSION w/ CIC	164	232	396	63	17	80	316
UNICARE MEDICARE EXTENSION w/o CIC	2	5	7	1	13	14	-7
UNICARE PLUS	303	652	955	79	290	369	586
Grand Totals	**2,216**	**2,778**	**4,994**	**787**	**2,778**	**3,564**	**1,428**

Plan Name	ALLWAYS HEALTH PARTNERS	FALLON DIRECT CARE	FALLON SELECT	HARVARD PILGRIM IND	HARVARD PILGRIM MEDICARE ENHANCE	HARVARD PILGRIM PRIMARY CHOICE	HEALTH NEW ENG	HEALTH NEW ENG MEDICARE SUPPLEMENT PLUS	TUFTS MEDICARE COMP	TUFTS MEDICARE PREFERRED	TUFTS NAVIGATOR	TUFTS SPIRIT	UNICARE MEDICARE EXTENSION w/o CIC	UNICARE BASIC w/ CIC	UNICARE BASIC w/o CIC	UNICARE COMMUNITY CHOICE	UNICARE MEDICARE EXTENSION w/ CIC	UNICARE PLUS	Total IN
ALLWAYS HEALTH PARTNERS		3	4	8		14	5				24	15		6		10		12	**101**
FALLON DIRECT CARE	4		8	1		2					3	2		1		7			**28**
FALLON SELECT	1	39		3		3	2				4	6		1				1	**60**
HARVARD PILGRIM IND	9	10	6		3	82	9				26	7		10		15		20	**197**
HARVARD PILGRIM MEDICARE ENHANCE	1		1	38		9		2	4	4							5		**64**
HARVARD PILGRIM PRIMARY CHOICE	14	16	4	26			1				15	13		1	1	12		6	**109**
HEALTH NEW ENG	7	11	2			2					18	7		11	1	17		11	**87**
HEALTH NEW ENG MEDICARE SUPPLEMENT			1				9			1									**11**
TUFTS MEDICARE COMP	1				4		1	1		38	29	4				2	6	1	**87**
TUFTS MEDICARE PREFERRED					2	1	1	1	2		4						2		**13**
TUFTS NAVIGATOR	29	24	16	36		34	12		1	1		102		25	1	31		26	**338**
TUFTS SPIRIT	12	11	1	1		7	4				25			2	1	10		6	**80**
UNICARE BASIC w/ CIC	10	2	9	45		24	11				100	6			16	57	3	79	**362**
UNICARE BASIC w/o CIC		1	1	8		5	2				12	3		5		19		8	**64**
UNICARE COMMUNITY	37	16	3	16		28	18				38	26		38	7			72	**299**
UNICARE MEDICARE		2		6	18	2	3	4	28	12	11	1	13	64		20		48	**232**
UNICARE MEDICARE					1				2					1				1	**5**
UNICARE PLUS	43	21	24	42		43	31				137	31		83	9	176	1		**641**
Total OUT	**168**	**156**	**80**	**230**	**28**	**256**	**109**	**8**	**37**	**56**	**446**	**223**	**13**	**248**	**36**	**376**	**17**	**291**	**2778**

2021 Annual Enrollment

- Retiree Dental
  - New Enrollments for July 1, 2021----898
  - Total Retiree Dental Enrollments-----40,608

- Buyout Applications
  - 109 Buyout applications processed for July 1. 2021

MAGIC
Group Insurance Commission

ENROLLMENT SUMMARY

For July 2021

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Members By Product (Medicare & Non-Medicare)	State		Municipality		Total
	Individual	Family	Individual	Family	
ALLWAYS HEALTH PARTNERS	2,807	7,781	1,245	4,987	16,820
FALLON DIRECT CARE	1,294	3,796	555	1,112	6,757
FALLON SELECT	965	4,565	344	2,411	8,285
HARVARD PILGRIM INDEPENDENCE	5,127	21,851	1,752	8,476	37,206
HARVARD PILGRIM MEDICARE ENHANCE	10,386	0	6,749	0	17,135
HARVARD PILGRIM PRIMARY CHOICE	3,053	10,380	1,911	7,658	23,002
HEALTH NEW ENG	3,903	13,324	1,481	5,551	24,259
HEALTH NEW ENG MEDICARE SUPPLEMENT PLUS	2,561	0	865	0	3,426
TUFTS MEDICARE COMPLEMENT	8,025	0	3,062	0	11,087
TUFTS MEDICARE PREFERRED	3,076	0	1,495	0	4,571
TUFTS NAVIGATOR	9,692	44,732	3,367	16,547	74,338
TUFTS SPIRIT	2,018	3,659	1,100	1,629	8,406
UNICARE BASIC w/ CIC	7,536	13,528	1,392	2,145	24,601
UNICARE BASIC w/o CIC	272	661	11	30	974
UNICARE COMMUNITY CHOICE	6,176	27,274	2,417	8,063	43,930
UNICARE MEDICARE EXTENSION w/ CIC	56,254	0	19,269	0	75,523
UNICARE MEDICARE EXTENSION w/o CIC	309	0	38	0	347
UNICARE PLUS	5,760	24,560	1,951	8,931	41,202
Totals	**129,214**	**176,111**	**49,004**	**67,540**	**421,869**

FY2022 Flexible Spending Account Enrollment

Commonwealth of Massachusetts Group Insurance Commission
Your Benefits Connection

Reminder: To allow members additional time to utilize their account balances, and reduce the risk of forfeiting unspent funds, the GIC has extended the Grace Period for both FY2020 (until 6/30/21) and FY2021 (through 12/31/2021).

FSA Enrollment Summary FY19 – FY22

Plan Year	Unique Members	HCSA Accounts	DCAP Accounts	Total Elections
FY 2022	**14,503**	**14,049**	**1,871**	**$ 32,386,504**
FY 2021	15,260	14,807	1,848	$ 32,068,402
FY 2020	16,124	15,470	2,568	$ 36,715,442
FY 2019	16,783	16,055	2,659	$ 36,667,298

- While overall FY22 enrollment in FSA plans decreased 5% compared to prior year, withholding elections *increased* 1%.
- DCAP Enrollment is expected to increase throughout the plan year as more employees/spouses return to work and daycare facilities reopen. A change in daycare costs (including a child returning to daycare or a spouse returning to work) is already a qualifying event to change or add DCAP enrollment and will remain so.

VIII. Other Business/Adjournment

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

FY21 GIC Commission Meeting Schedule

- Unless otherwise announced in the public notice, all meetings take place from 8:30 am - 10:30 am on the 3rd Thursday of the month.
- Meeting notices and materials including the agenda and presentation are available at www.mass.gov/gic under Upcoming Events prior to the meeting and under Recent Events after the meeting.

Please note these exceptions:

- February's meeting is scheduled on the 2nd Thursday and March's meeting is scheduled on the 1st Thursday to make decisions regarding the next Benefit Year in a timely manner prior to Annual Enrollment in May.

Please note these changes:

- Until the ban on public gatherings is lifted, Commissioners will attend meetings remotely via a video-conferencing platform provided by GIC.
- Anyone with Internet access can view the livestream via the MA Group Insurance Commission channel on YouTube. The meeting is recorded, so it can be replayed at any time.

FY2022 Group Insurance Commission Meetings

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

July 2021

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

August 2021

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

September 2021

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

October 2021

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

November 2021

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

December 2021

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

January 2022

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February 2022

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

March 2022

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2022

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May 2022

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 2022

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

APPENDIX

- Commission Members
- GIC Leadership Team
- GIC Goals
- GIC Contact Channels

Commission Members

- Valerie Sullivan (Public Member), Chair
- Michael Heffernan, Secretary of Administration & Finance
- Elizabeth Chabot (NAGE)
- Edward Tobey Choate (Public Member)
- Tamara P. Davis (Public Member)
- Jane Edmonds (Retiree Member)
- Eileen P. McAnneny (Public Member)
- Melissa Murphy-Rodrigues (Mass Municipal Association)
- Bobbi Kaplan (NAGE), Vice-Chair
- Gary Anderson, Commissioner of Insurance
- Adam Chapdelaine (Mass Municipal Association)
- Christine Clinard (Public Member)
- Gerzino Guirand (Council 93, AFSCME, AFL-CIO)
- Joseph Gentile (Public Safety Member)
- Patricia Jennings (Public Member)
- Anna Sinaiko (Health Economist)
- Timothy D. Sullivan (Massachusetts Teachers Association)

GIC Leadership Team

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Matthew A. Veno, Executive Director

Erika Scibelli, Deputy Executive Director

Emily Williams, Chief of Staff

John Harney, Chief Information Officer

Paul Murphy, Director of Operations

James Rust, Chief Fiscal Officer

Andrew Stern, General Counsel

Brock Veidenheimer, Director of Human Resources

Mike Berry, Director of Legislative Affairs

GIC Goals

- Provide access to high quality, affordable benefit options for employees, retirees and dependents
- Limit the financial liability to the state and others (of fulfilling benefit obligations) to sustainable growth rates
- Use the GIC's leverage to innovate and otherwise favorably influence the Massachusetts healthcare market
- Evolve business and operational environment of the GIC to better meet business demands and security standards

Commonwealth of Massachusetts
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Your Benefits Connection

Contact GIC for Enrollment and Eligibility

Enrollment	Retirement	Premium Payments
Qualifying Events	Life Insurance	Long-Term Disability
Information Changes	Marriage Status Changes	Other Questions

Online Contact	mass.gov/forms/contact-the-gic	Any time. Specify your preferred method of response (phone, email, mail) from GIC
Email	gicpublicinfo@mass.gov	
Telephone	(617) 727-2310	M-F from 8:45 AM to 5:00 PM
Office location	19 Staniford Street Boston, MA 02114	Not open for walk-in service during COVID-19
Correspondence	P.O. Box 8747 Boston 02114	Allow for processing time. Priority given to requests to retain or access benefits, and to reduce optional coverage during COVID-19.
Paper Forms	P.O. Box 556 Randolph, MA 02368	

Commonwealth of Massachusetts
Group Insurance Commission
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Contact Your Health Carrier for Product and Coverage Questions

Finding a Provider

Accessing tiered doctor and hospital lists

Determining which programs are available, like telehealth or fitness

Understanding coverage

Health Insurance Carrier	Telephone	Website
AllWays Health Partners	(866)-567-9175	allwayshealthpartners.org/gic-members
Fallon Health	(866) 344-4442	fallonhealth.org/gic
Harvard Pilgrim Health Care	(800) 542-1499	harvardpilgrim.org/gic
Health New England	(800) 842-4464	hne.com/gic
Tufts Health Plan (THP)	(800) 870-9488	tuftshealthplan.com/gic
THP Medicare Products	(888) 333-0880	
UniCare State Indemnity Plans	(800) 442-9300	unicarestateplan.com