Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Commission Meeting

May 20, 2021

(Public Notice: G.L. C-30A, Sec. 20, May 17, 2021)

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Agenda

	Topic	Speaker	Time
I.	Approval of 04/15/2021 Minutes (VOTE)	Valerie Sullivan, Chair	8:30-8:35
II.	Executive Director's Report (INFORM) • Calendar • Human Resources • Communications/Legislation/Municipalities • Annual Enrollment • Move Update • COVID-19 • Engagement	Matthew Veno, Executive Director & Members of Senior Staff	8:35-8:45
III.	BH Strategy (INFORM) • Brief intro • HHS roadmap	Matthew Veno, Executive Director & Lauren Peters, Undersecretary for Health Policy Executive Office of Health & Human Services	8:45-9:20
IV.	Dependent Care Assistance Plan (DCAP) FSA (UPDATE)	Matthew Veno, Executive Director Cameron McBean, Manager, Health & Ancillary Benefits	9:20-9:30
V.	Cost Drivers (INFORM) • Provider Prices • Prescription Drugs	Matthew Veno, Executive Director Margaret Anshutz, Manager, Healthcare Analytics & Deven Shah, RPh, MBA Willis Towers Watson Jannine Dewar, Manager of Pharmacy & Ancillary Benefits	9:30-10:15
VI.	CFO UPDATE (INFORM) • COVID claims update • FY21 spending to date	Jim Rust, Chief Financial Officer	10:15-10:25
VII.	Other Business/Adjournment • FY22 Commission Dates	Valerie Sullivan, Chair	10:25-10:30

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I. Approval of Minutes (VOTE)

Motion:

That the Commission hereby approves the minutes of its meeting held on April 15, 2021 as presented.

- Valerie Sullivan, Chair
- Bobbi Kaplan, Vice-Chair
- Cassandra Roeder
- Niels Puetthoff
- 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

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II. Executive Director's Report (INFORM)

- Calendar
- Human Resources
- Communications/Legislation/Municipalities
- Annual Enrollment
- Move Update
- COVID-19
- Engagement

Matthew Veno, Executive Director
&
Members of Senior Staff

II. Executive Director's Report: Calendar

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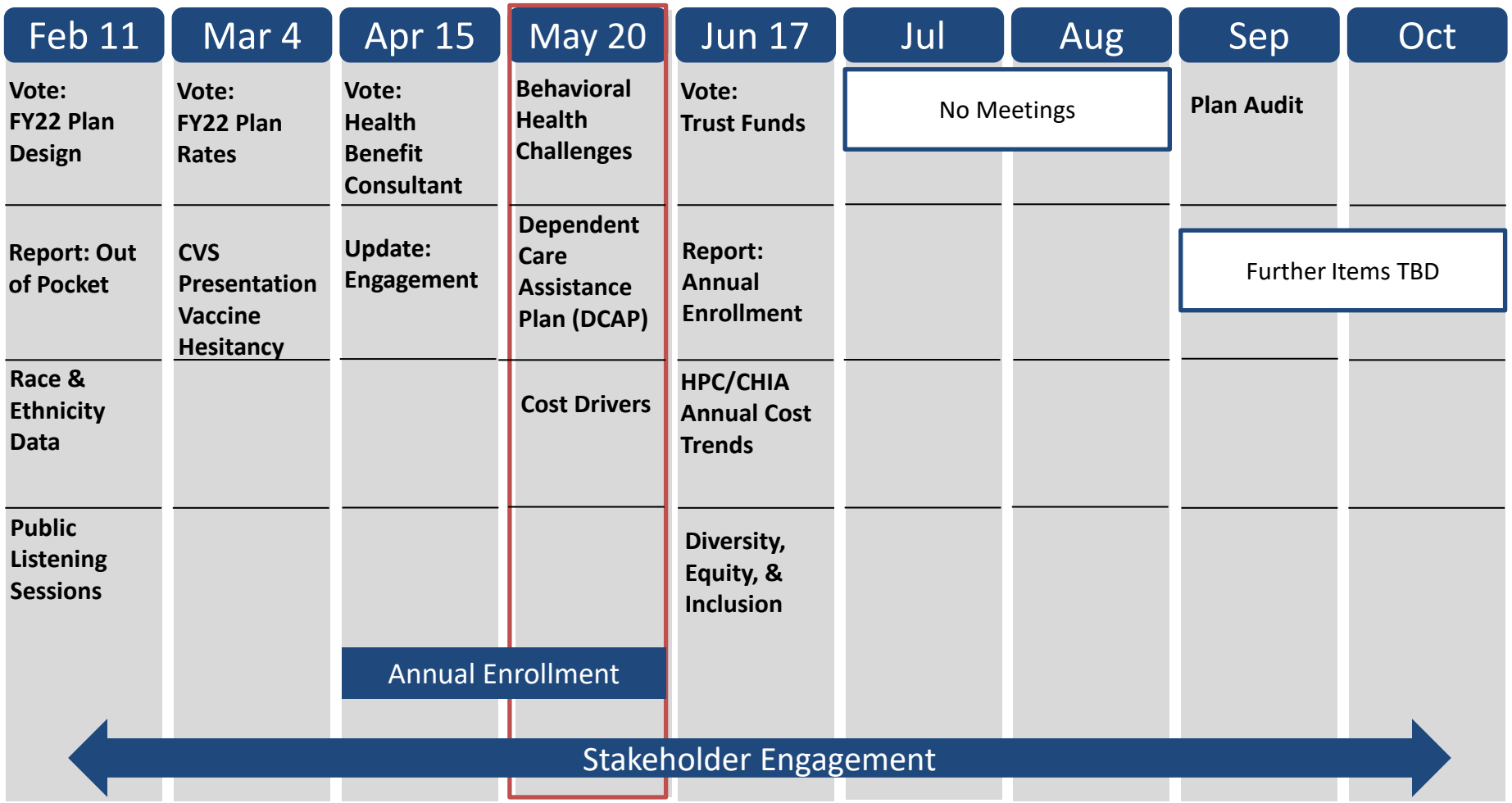

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II. Executive Director's Report (INFORM)

- Human Resources
- Communications/Legislation/Municipalities
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Matthew Veno, Executive Director
&
Members of Senior Staff

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III. Behavioral Health (INFORM)

Matthew Veno, Executive Director

Challenges to Behavioral Health Access

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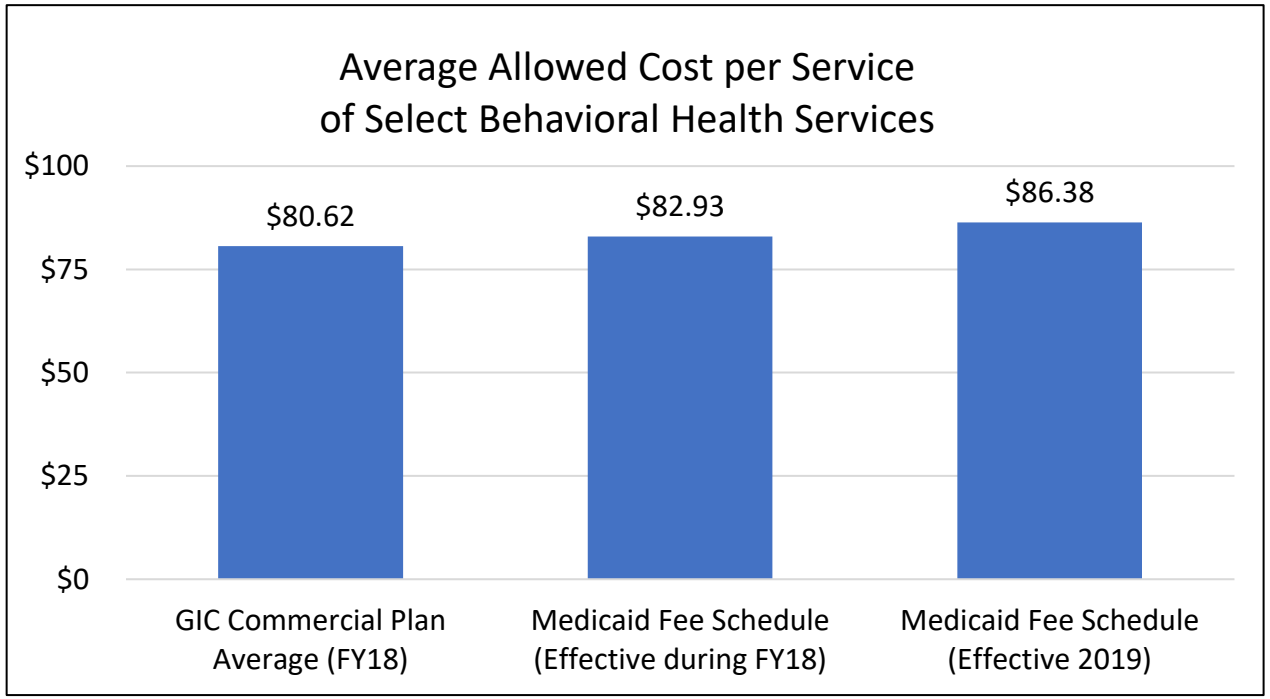
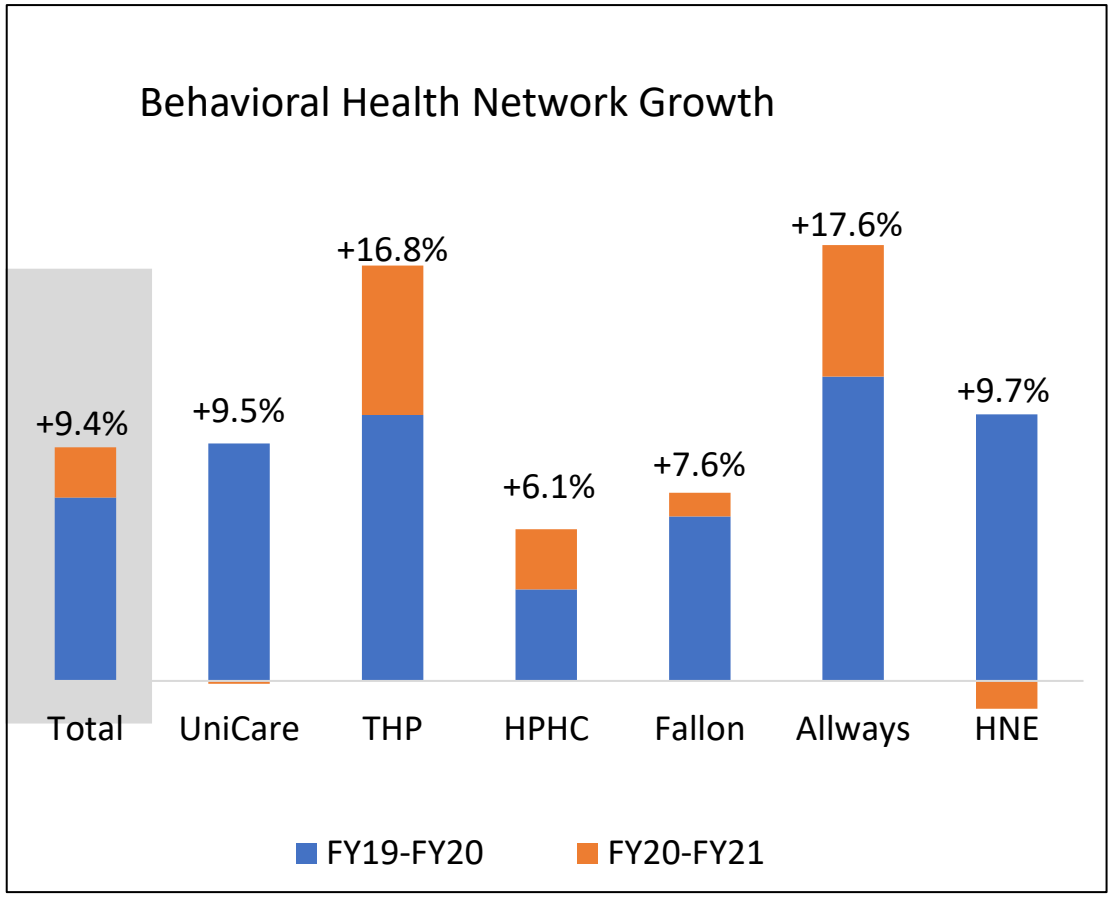
Steps Taken to Meet GIC Member Behavioral Health Needs

- "Carved-in" behavioral health to promote greater integration with medical care
- Launched the Mass4You Employee Assistance Plan (EAP)
- Made modest cost sharing adjustments to comply with Mental Health Parity laws
- Directed carriers to increase reimbursement for behavioral health services

Findings of FY19 Evaluation of Carrier Reimbursement for Behavioral Health Services



Behavioral Health Network Growth



Year over year network growth as reported by each health plan
Fallon data includes all of New England; all other venders are Massachusetts only
Unicare FY20-21 was a decrease of 0.1%
HNE FY20-21 was a decrease of 1.1%

Key Insights

- From FY19 to FY20, the GIC's over-all network of providers and facilities in Massachusetts increased 9.4%
- Data suggests that network access is increasing in most counties, including traditionally underserved communities
  - Franklin county showed decreased network access for several plans
- The GIC will continue to work with the plans to provide additional data and continue efforts to increase access

III. Behavioral Health (INFORM)

- HHS roadmap

Lauren Peters, Undersecretary Health Policy
Executive Office Health & Human Services

Roadmap for Behavioral Health Reform: Ensuring the right treatment *when* and *where* people need it

Executive Office of Health and Human Services

A Multi-Year Plan: Summary

February 2021

Historical, Structural Challenges in Behavioral Health

Structural challenges in access to mental health and addiction treatment remain, even after recent improvements made through legislation, policy reforms, and substantial public investment

- This **Roadmap is based upon statewide listening sessions and feedback** in 2019. Nearly 700 individuals, families, and others identified challenges and gaps in the system:
  - **Individuals and families often don't know what services are available** or how to connect to them.
  - **Not enough behavioral health providers accept insurance** (public or private); those that do may have long waiting lists.
  - **People often turn to the emergency department during a behavioral health crisis** because there is no effective system for immediate urgent care in the community.
  - **Individuals often can't get mental health and addiction treatment at the same location**, even though mental health conditions and substance use disorder (SUD) often co-occur.
  - **Culturally competent behavioral health care** for racially, ethnically and linguistically diverse communities can be difficult to find.

Historical, Structural Challenges in Behavioral Health (cont.)

Structural challenges in access to mental health and addiction treatment remain, even after recent improvements made through legislation, policy reforms, and substantial public investment

- The **impact of the COVID-19 pandemic on mental health and addiction needs has heightened the urgency** of creating and implementing sustainable solutions.
- At the onset of the pandemic, behavioral health utilization dropped by about half. However, **as providers pivoted to adopt telehealth, utilization quickly rebounded**.
  - MassHealth had begun covering telehealth for behavioral health services in February 2019, and during the pandemic expanded this coverage to include audio-only telehealth and reduce barriers for providers to adopt telehealth.
  - Among MassHealth members, 75% of behavioral health visits were happening via telehealth, with some providers experiencing 90% of their visits via telehealth.
- Thanks to the **Legislature's work codifying insurance coverage for telehealth services including behavioral health care** through comprehensive health care legislation.

Summary: Roadmap for Behavioral Health Reform

The Baker-Polito Administration proposes a Roadmap for Behavioral Health Reform that helps people find the right treatment when and where they need it.

Critical behavioral health system reforms through the Roadmap will include:

- A "**front door**" for people to get connected to the right treatment in real time
  - A **new, centralized service for people or their loved ones to call or text to get connected to mental health and addiction treatment**
  - This front door will help people connect with a provider before there's a mental health emergency, for routine or urgent help in their community, or even right at home

- **Readily available outpatient evaluation and treatment (including in primary care)**
  - More **mental health and addiction services available through primary care**, supported by new reimbursement incentives
  - **Same-day evaluation and referral to treatment**, evening/weekend hours, timely follow-up appointments, and evidence-based treatment in person and via telehealth at designated **Community Behavioral Health Centers (CBHCs)** throughout the Commonwealth

- Better, more convenient **community-based alternatives to the emergency department** for urgent and crisis intervention services
  - **Urgent care for behavioral health** at CBHCs and other community provider locations
  - A stronger system of **24/7 community and mobile crisis intervention**

- **Expanded inpatient psychiatric bed capacity** to meet needs exacerbated by COVID-19

Summary: Roadmap for Behavioral Health Reform (cont.)

The Roadmap proposes a multi-year blueprint for the Commonwealth. Its success depends on the support and commitment of private health plans and providers.

The Roadmap also proposes to:

- **Advance health equity to meet the diverse needs** of individuals and families, particularly from historically marginalized communities
- **Encourage more providers to accept insurance** by reducing administrative and payment barriers
- **Broaden insurance coverage for behavioral health**
- Implement **targeted interventions to strengthen workforce diversity and competency**

These reforms do not replace or disrupt existing services or provider relationships—rather they aim to **help individuals and families more quickly and easily get connected to the treatment they need**.

The **Baker-Polito Administration is investing $40 million in FY21** to expand inpatient bed capacity, and the Governor's proposed **FY22 budget includes $84 million**, plus $70 million from the SUD Trust, to support the public sector components of the Roadmap. **Over the next 3 years, estimated new public expenditures will increase to over $200 million.**

Beyond these public sector expenditures, the **success of this critical statewide effort depends on commercial insurers** also committing to and investing in the proposed reforms

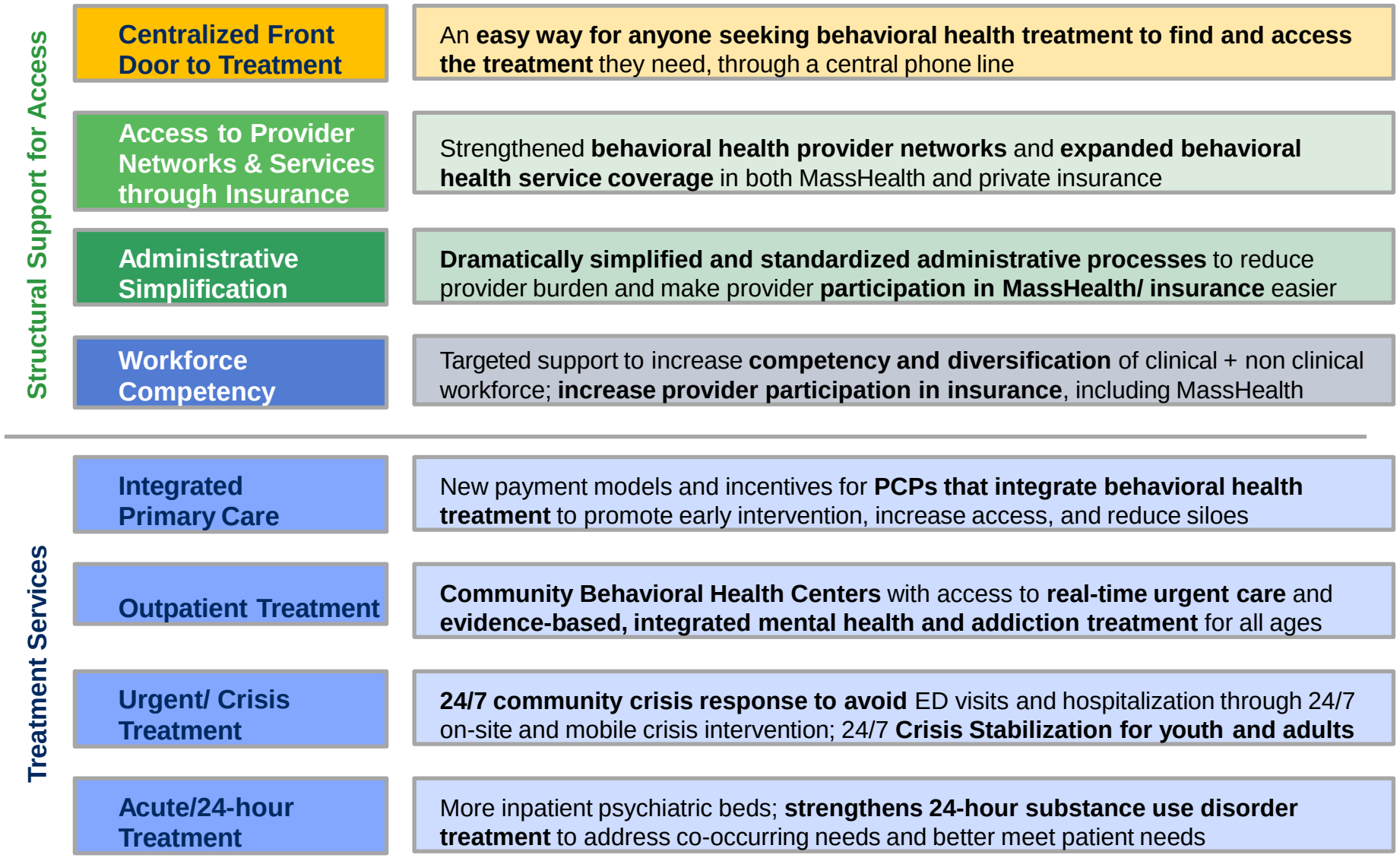
Principles of a Behavioral Health Treatment System

A system should provide treatment to individuals, families, and communities from birth throughout the lifespan and across the continuum from prevention and early intervention through recovery support

System Principles

- Ensure **parity** between physical and behavioral healthcare
- Expand **provider networks** through MassHealth and private insurance
- Expand **timely outpatient and urgent care access** to promote early intervention and to reduce crises
- **Integrate** the delivery of mental health and addiction treatment, and integrate behavioral and physical healthcare
- Ensure treatment is based on **goal-oriented, trauma-informed evidence-based practices** for individuals across the age spectrum, with specialized services for complex and high-risk populations
- Support **health equity** by ensuring capacity to meet the diverse needs of all individuals in Commonwealth, including those that are systematically disadvantaged
- Require **“no-reject”** of individuals who need treatment, including returning patients

Proposed Reforms through the Behavioral Health Roadmap



Centralized Front Door to Treatment

Individuals and families should have an easy way to get the behavioral health services they need

- **Creating a new behavioral health treatment system will only succeed if people are able to access it easily**
- Through the Roadmap, EOHHS will create an easily accessible “front door” to behavioral health treatment
- **A new centralized phone/ chat line will enable people to easily find available providers and services that meet their needs**
  - The phone line will offer more than just a list of phone numbers, **providing real-time live clinical triage and service navigation in multiple languages**
  - The front door will help individuals and families to fully access the range of comprehensive treatment services for mental health and addiction offered in the Commonwealth, including **outpatient, urgent and immediate crisis intervention**
  - While the new front door is developed, the statewide 211 information line will direct people to existing available resources (e.g., DPH Substance Use Helpline, Mass Support crisis counseling line, Network of Care directory) and raise awareness about the statewide toll-free behavioral health crisis line

Readily available outpatient evaluation and treatment in the community and primary care

Newly designated **Community Behavioral Health Centers** and **increased behavioral health services in primary care** will expand the availability of outpatient evaluation and treatment in communities across the Commonwealth

- **Community Behavioral Health Centers (CBHCs)** will act as an **entry point for timely assessment and connection to behavioral health treatment**. CBHCs will:
  - Offer **behavioral health urgent care** and same-day assessment and referral to treatment, timely follow-up appointments, and a broad range of ongoing treatment services for **mental health and addiction**
  - Be required to meet a **high bar for timely access; evidence-based, integrated treatment; and cultural competency,** serving **all ages from children to older adults**
  - **CBHCs are likely to be existing behavioral health providers** that build their capacity to meet the new standards and develop referral partnerships with other community providers
- **Increasing the integration of behavioral health in primary care** will promote early intervention and ease demand on specialty behavioral health providers
  - In many cases, **mild to moderate behavioral health conditions can be managed by primary care providers,** in consultation and coordination with specialty providers as needed, similar to how many chronic medical conditions are managed
  - The Roadmap proposes **increased and value-based payments** for providers that deliver integrated mental health and addiction services in primary care

Community-based alternatives to the emergency department

Create a stronger 24/7 community-based crisis response system that reduces reliance on the Emergency Department (ED) for behavioral health crises

A stronger system of community-based behavioral health crisis care will offer an alternative to the ED by:

- Creating more widely available **behavioral health urgent care** with evening and weekend hours, through CBHCs and other providers
- **Developing a new regional crisis system embedded within Community Behavioral Health Centers (CBHCs) that will deliver 24/7 community and mobile crisis intervention to prevent unnecessary hospitalization and ED visits**
- Establishing **Community Crisis Stabilization (CCS) for youth** to provide short-term, intensive 24-hour treatment, expanding a service currently only available for adults
- Making **real-time expert consultation available to support crisis teams** responding to individuals with **Autism Spectrum Disorder and Intellectual/ Developmental Disabilities**
- **Shifting responsibility to hospitals for behavioral health crisis evaluations in their own emergency departments**, just as they are responsible for physical health evaluations

Advancing health equity

The Roadmap is designed to reduce health disparities in race, language, and physical ability

- **Diversifying the workforce** to be more reflective of the Commonwealth:
  - Provide loan repayment incentives for clinicians with diverse cultural, racial, ethnic, and linguistic backgrounds and competence
  - Expand coverage of peers for mental health and addiction
- **A multi-lingual "front door," including ASL interpreters**
- **Providing treatment when and where people need it** to reduce disparities in access to behavioral health services related to transportation, time off from work and childcare
  - Maintain broad coverage of telehealth
  - Expand the availability of integrated behavioral health services within primary care
  - Extended hours, including weekends, at CBHCs and behavioral health urgent care
- **Providing culturally competent care**
  - Require CBHCs to provide services in clients' preferred language (including ASL)
  - Require CBHCs to provide tailored services for populations such as individuals who are justice involved, individuals with ASD/IDD, and youth in the care and custody of the Commonwealth
  - Offer training for behavioral health providers in evidence-based practices (e.g., trauma-informed therapies) that better meet the needs of Massachusetts' diverse populations

Encouraging more providers to accept insurance & broaden insurance coverage

Strengthen behavioral health provider networks and expand behavioral health service coverage in both MassHealth and private insurance

- Simplify administrative processes for behavioral health providers to make it easier for providers to participate in MassHealth and private insurance
  - Require **standardized behavioral health provider credentialing** processes*
- Create a **single, broad behavioral health provider network for MassHealth members** to dramatically simplify the MassHealth system for both providers and members**
- Make it easier to find a provider that accepts your insurance by increasing oversight of commercial behavioral health provider networks including **accurate and timely provider directories**
- **Continue broad commercial and MassHealth coverage of tele-behavioral health***
- **Targeted initiatives to increase provider participation in MassHealth and strengthen workforce diversity and competency**
  - Including loan repayment incentives, targeted rate increases, and training
- **Expand MassHealth coverage,** including recovery coaches, peer specialists, and independent psychologists and social workers, and work with commercial insurers to also expand coverage

* As required in recent legislation
**Single BH network for ACO, MCO, PCC Plan; excludes SCO, OneCare and Fee-for-Service

Behavioral Health Roadmap and Related Initiatives Timeline

- Telehealth coverage expansion
- Commercial coverage for child & adolescent MH services
- Increased DOI oversight of commercial BH provider networks
- ASD/IDD consultation service for mobile crisis teams
- Incentives to expand inpatient and respite bed capacity

- MassHealth Recovery Coach expansion
- DPH and MassHealth regulatory flexibilities
- Expanded primary care billing for BH integration
- Community Behavioral Health Centers (CBHC)
- Behavioral Health urgent care
- New clinical standards and regulatory flexibility for 24-hour SUD treatment
- Modernized Child and Adolescent Needs and Strength (CANS) Assessment Tool
- Office Based Addiction Treatment expansion
- Expansion of school “bridge” programs (intensive post-hospitalization services)
- Standardized medical clearance guidelines

- Restructured crisis system
- New Youth Community Crisis Stabilization service
- Expanded network of providers with rapid access to Medication Assisted Treatment (MAT) (bridge clinics)
- Centralized front door to treatment
- Expanded clinician training in Evidence Based Practices
- Centralized inpatient bed finding process
- MassHealth direct enrollment of independent psychologists & LICSWs

- Single provider network across MassHealth ACO/MCO/PCC plans
- MassHealth coverage of Certified Mental Health Peer Specialists
- Value based payment models for primary care with fully integrated BH

Additional Detail

Executive Office of Health and Human Services

March 2021

Centralized Front Door to Treatment

Individuals and families should have an easy way to get the behavioral health services they need

- **Today, people often don't know what behavioral health services are available or how to access them** due to stigma, lack of awareness, and complexity in the array of services
- **Creating a new behavioral health treatment system will only succeed if people are able to access it easily**
- The new system creates an easily accessible "front door" to behavioral health treatment
  - **A new centralized phone/ chat line will enable people to easily find available providers and services that meet their needs**
    - The phone line will offer with real-time live clinical triage and service navigation in multiple languages, to help individuals and families to fully access the range of comprehensive services offered in the Commonwealth, including outpatient, urgent and immediate crisis intervention
    - While the new Front Door is developed, EOHHS will ensure that the **statewide 211 information line** directs people to existing available resources (e.g., DPH Substance Use Helpline, Mass Support program crisis counseling line, Network of Care directory) and raise awareness about the **statewide toll-free behavioral health crisis line**

Readily Available Outpatient Evaluation and Treatment in the Community and Primary Care

Newly designated **Community Behavioral Health Centers** and **increased behavioral health services in primary care** will expand the availability of outpatient evaluation and treatment in communities across the Commonwealth

- **Community Behavioral Health Centers (CBHCs)** will act as an **entry point for timely assessment and connection to behavioral health treatment**. CBHCs will:
  - Offer **behavioral health urgent care** and same-day assessment and referral to treatment, timely follow-up appointments, and a broad range of ongoing treatment services for **mental health and addiction**
  - Be required to meet a **high bar for timely access; evidence-based, integrated treatment; and cultural competency,** serving **all ages from children to older adults**
  - **CBHCs are likely to be existing behavioral health providers** that build their capacity to meet the new standards and develop referral partnerships with other community providers
- **Increasing the integration of behavioral health in primary care** will promote early intervention and ease demand on specialty behavioral health providers
  - In many cases, **mild to moderate behavioral health conditions can be managed by primary care providers,** in consultation and coordination with specialty providers as needed, similar to how many chronic medical conditions are managed
  - The Roadmap proposes **increased and value-based payments** for providers that deliver integrated mental health and addiction services in primary care

Community Behavioral Health Centers

Community Behavioral Health Centers will **serve as an entry point for timely, high-quality mental health and addiction treatment on an urgent and ongoing basis**; and receive enhanced funding to support flexible, person-centered treatment

- A key component of the Roadmap is the development of a **new system of designated Community Behavioral Health Centers (CBHCs)** that will:
  - Serve as an **entry point for timely assessment and connection to appropriate behavioral health treatment**, taking the burden off of individuals and families to figure out what they need and how to find a provider
  - Offer **behavioral health urgent care** and same-day access to treatment or assessment
  - Become **regional hubs** for behavioral health, with at least one per county
  - Provide a **broad range of mental health and addiction treatment services** with same day access, urgent care, ongoing treatment services, and referral to additional providers
- CBHCs will be required to meet a **high bar for timely access; evidence-based, integrated treatment delivery; and cultural competency**
- In order to support this model, **MassHealth will provide increased reimbursement rates and a flexible payment model** that supports high-quality, outcomes-oriented and individualized care delivery
- **Commercial insurers are strongly encouraged to adopt the CBHC care delivery and reimbursement model** to ensure that all Massachusetts residents have access to CBHCs
- CBHCs will apply and be selected in mid-2021 and will be fully implemented by early 2022

Community Behavioral Health Centers (continued)

Community Behavioral Health Centers will **serve as an entry point for timely, high-quality mental health and addiction treatment on an urgent and ongoing basis**; and receive enhanced funding to support flexible, person-centered treatment

Key components of CBHCs:

- **Integrated mental health, addiction treatment, and urgent medical treatment**
- **Extended hours** including evenings and weekends
- **Same-day access to intake and brief assessment, urgent and crisis care** including medications, and drop-in services (e.g., group sessions, peer supports)
- **24/7 mobile and community crisis response** with Community Crisis Stabilization for youth and adults
- **Telehealth** and flexible service delivery location (e.g., home, school, etc.)
- Focus on **quality and outcomes**, including offering trauma-informed evidence-based practices and peer supports
- **Patient/family outreach, engagement, and care coordination**
- **Ability to serve all ages across the continuum of care**, including child and family-specific treatment models and models for older adults (through single organization or partnership of two that includes a child-focused provider)
- **Language and cultural competencies:** Provide core services in clients' preferred language (including ASL) or access to trained interpreter, as well as culturally competent staff and treatment for racially and ethnically diverse communities
- **Special populations:** Provide tailored services to meet the needs of special populations such as justice involved, ASD/IDD, youth in the care and custody of the Commonwealth
- **Move away from fee-for-service** to payment that enables flexible approach to meet individualized patient needs with sufficient, reliable funding

Integrated Primary Care

Increasing the number of primary practices able to manage mild to moderate BH conditions, and to coordinate with specialty BH, will increase BH access

Vision

Mild to moderate BH conditions are identified and treated as a routine part of primary care through an integrated, team-based approach. Primary care practices refer to and coordinate with the specialty BH system to treat individuals with acute or complex chronic BH conditions, just as they do for acute or complex chronic medical conditions.

Principles

Patient-centered
(same-day, tele-capable)

Team-based
(including peers, support staff)

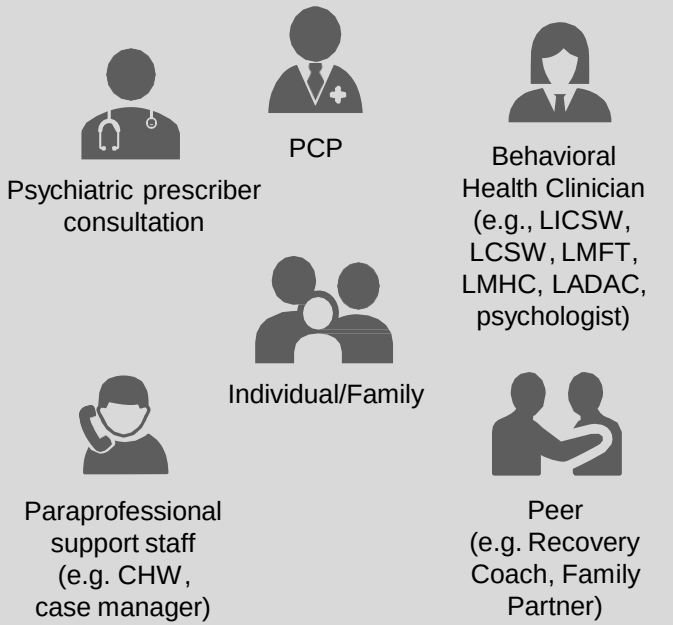
Coordinated
(communicate across team and with specialty BH)

Data-driven
(monitoring patient outcomes)

Capabilities

- **Screen universally for mental health conditions and SUD**
- **Provide assessment of and treatment for** mild to moderate BH conditions (e.g., depression, anxiety, ADHD, SUD), including prescribing appropriate medications
- **BH clinicians and support staff act as part of primary care team** with unified treatment plan to coordinate patient care
- **Refer to and coordinate with** specialty BH providers when condition requires more specialized treatment
- **Maintain continuous relationship and monitor progress over time** using Patient-Centered Outcomes Measures

Integrated Care Team



Illustrative Practice Model

Integrated Primary Care (continued)

Health insurance payers should provide incentives for primary care practices with integrated behavioral health

- Currently, only **a minority of primary care practices offer integrated behavioral health care;** goal is to **shift more routine behavioral health treatment into primary care** to increase access, promote early intervention, reduce stigma and siloes, and ease demand on the specialty BH system
- **Roadmap approach:**
  - **Set a higher bar for expectations** of integration in primary care practices
  - **Increase reimbursement/ investments for PCPs that meet the higher bar**, in addition to allowing same day billing of BH and PCP services and reimbursing for BH integration activities that are currently not covered
- **MassHealth Phased approach:**
  - Phase 1 (2021-2022): **MassHealth will pay for previously unreimbursed integrated behavioral health services** (e.g., warm hand-offs, team based care planning, monitoring & follow-up for BH)
  - Phase 2 (2023): **New PCP payment and reimbursement structure** through the next 1115 waiver:
    - Primary care sub-capitation with investment: PMPM to allow PCPs to flexibly meet patient needs
    - Investment and subcap available for PCPs that meet high standards, including on BH integration
- **Commercial insurance carriers will be strongly encouraged to align with these payment policies**

Community-Based Alternatives to the Emergency Department

Create a stronger 24/7 community-based crisis response system that reduces reliance on the Emergency Department (ED) for behavioral health crises

Today, individuals in behavioral health crisis often turn to the ED because there is no effective system and limited capacity for immediate, urgent care in the community

A stronger system of community-based behavioral health crisis care will offer an alternative to the ED by:

- Creating more widely available **behavioral health urgent care** with evening and weekend hours, through CBHCs and other providers
- **Developing a new regional crisis system embedded within Community Behavioral Health Centers (CBHCs) that will deliver 24/7 community and mobile crisis intervention to prevent unnecessary hospitalization and ED visits**. CBHC crisis teams will:
  - Focus solely on 24/7 community and mobile response
  - Have clinical staff capable of addressing both mental health and addiction for diverse populations and all ages
  - Form partnerships with Emergency Medical Services (EMS) and local law enforcement
- Establishing **Community Crisis Stabilization (CCS) for youth** to provide short-term, intensive 24-hour treatment, expanding a service currently only available for adults
- **Making real-time expert consultation available to support crisis teams responding to youth with Autism Spectrum Disorder and Intellectual/ Developmental Disabilities**
- **Shifting responsibility to hospitals for behavioral health crisis evaluations in their own emergency departments**, just as they are responsible for physical health evaluations

Timely Access to Inpatient & 24-Hour Treatment

EOHHS is taking immediate steps to address the need for additional inpatient psychiatric bed capacity due to COVID and planning further efforts to streamline inpatient admissions

- **Immediately increase inpatient psychiatric bed capacity to meet emergent demand through $30-40M in payment incentives** for near-term bed expansion, including rate incentives of 25-30% and support for constructing new beds, including specialized units (e.g., ASD/IDD) (2021)
- Expand **~50 DMH respite beds** statewide to increase step-down options for patients with complex needs being discharged from inpatient treatment (2020-21)
- Ensure that crisis teams, hospital ED providers, and consumers are aware of **24-hour diversionary treatment options** (e.g., Crisis Stabilization units, Community Based Acute Treatment for youth) and able to access the most appropriate level of care without delay
- **Reduce barriers to inpatient admission by standardizing medical clearance** with clear, evidence-based guidelines (2021)
- **Simplify and centralize the inpatient bed-finding process** by creating a more accessible and effective system to locate available provider capacity (2022)
- **Strengthen 24-hour SUD treatment** through new clinical standards, regulatory flexibility, and rate increases to improve clinical quality and patient flow (e.g., support treatment for co-occurring conditions, reduce disruption between levels of care for withdrawal and stabilization) (2021)

24-Hour Addiction Treatment

Strengthen 24-hour addiction treatment in Massachusetts by promoting strong clinical standards, increasing rates, creating regulatory flexibility, and expanding bed capacity

Current Challenges

- Increasingly, many patients receiving 24-hour addiction treatment also have **complex medical and/or mental health needs**
- Patients sometime experience **disruptions or bottlenecks when transitioning** from one treatment phase to another (i.e., between Acute Treatment Services (ATS) for withdrawal to Clinical Stabilization Services (CSS))
- **More beds are needed** to meet the Commonwealth's treatment and recovery supports needs

Proposed Solutions

- **Strengthen clinical standards, accompanied by rate increases**, to improve 24-hour addiction programs' capacity to treat patients with complex needs (2021)
- Create **regulatory flexibility** allowing more fluid transitions from ATS to CSS levels of care to **minimize disruptions and promote more individualized pathways** for treatment and recovery (2021)
- Continue **expansion of bed capacity** focusing on underserved populations and regions (2022-2023)

Behavioral Health Provider Networks and Services Through Insurance

Strengthen behavioral health provider networks and expand behavioral health service coverage in both MassHealth and private insurance

Continue broad commercial and MassHealth coverage of tele-behavioral health with rate parity, as required in recent MA health care Legislation (2020+)

Increase Division of Insurance oversight of commercial behavioral health provider networks including **accurate and timely provider directories** (i.e., addressing "ghost networks") (2020+)

Continue implementation of expanded **commercial coverage for youth mental health services** similar to MassHealth Children's Behavioral Health Initiative services (ongoing)

Create a **single, broad behavioral health provider network for MassHealth members** to dramatically simplify the MassHealth system for both providers and members* (2023)

Expand MassHealth coverage:

- Expand access to **Recovery Coaches** for SUD (2021)
- Directly contract with **independent psychologists and LICSWs** (2022)
- Cover Certified **Mental Health Peer Specialists** (2023)

Encourage **commercial insurers to support Roadmap**, e.g.:

- **Align contracting/ payment for integrated primary care and CBHCs**
- **Expand coverage** of peer supports and supervised clinicians in training

*Single BH network for ACO, MCO, PCC Plan; excludes SCO, OneCare and Fee-for-Service

Administrative Simplification

Simplify administrative processes for behavioral health providers to make it easier for providers to participate in MassHealth and private insurance

- **Finalize new Department of Public Health regulatory flexibilities,** including allowing providers to conduct brief assessments to initiate same-day treatment (2021)
- **Overhaul MassHealth community mental health center regulations** to integrate mental health and SUD and streamline administrative requirements (2021)
- Ensure full and consistent implementation of **standardized behavioral health provider credentialing processes** in both commercial insurance and MassHealth plans
- **Modernize the Child and Adolescent Needs and Strength (CANS)** assessment tool and implement an improved technology platform for CANS to **reduce documentation burden and promote clinical value** for the treatment of children and youth (2021)
- Create a **single, broad provider network for MassHealth members** to dramatically simplify provider enrollment and participation, and to make it easier for members to find and keep their behavioral health provider(s), even if they change plans* (2023)

*Single BH network for ACO, MCO, PCC Plan; excludes SCO, OneCare and Fee-For-Service

Workforce Competency & Insurance Participation

The Roadmap takes a targeted approach to behavioral health workforce challenges

- The Commonwealth has more qualified behavioral health providers than most states, but **too few providers accept insurance** or **deliver evidence-based, culturally competent treatment.**
- The Roadmap focuses on **targeted initiatives to increase provider participation in insurance (including MassHealth) and strengthen workforce diversity and competency**.

Provider Participation in Insurance/ MassHealth

- **Reduce administrative barriers** to participation in insurance, including MassHealth (e.g., single credentialing)
- Provide **loan repayments to behavioral health clinicians who make a multi-year commitment to practicing at a safety net/ MassHealth provider**
- Provide **targeted rate increases** to enable key providers (e.g., CBHCs, integrated primary care) to hire and retain more qualified staff
- Create **flexibility to more efficiently and effectively deploy workforce** (e.g., insurance coverage for telehealth, peer supports)

Workforce Competency

- Offer **training opportunities in defined set of evidence-based practices** for behavioral health clinicians as part of their continuing education
- Build on existing efforts to implement **certification standards** and **training for peer roles and Community Health Workers**
- Prioritize clinicians with **cultural and linguistic competency** for loan repayment to address unmet needs in the community

How the Roadmap Addresses the Specific Needs of Children, Youth and Families

Treatment for children, youth, and families should be designed to meet their specific needs at all points along the treatment continuum

The Roadmap builds upon the existing Children's Behavioral Health Initiative and similar services covered for commercially insured youth to strengthen behavioral health treatment access and services for *all* youth in Massachusetts.

This includes several strategies tailored for children, youth and families:

- Building on the success of high behavioral health screening rates in pediatric primary care in MA by increasing **integration of BH clinicians** through warm handoffs and evidence-based treatment tailored to children, youth and families (e.g., including family supports)
- Ensuring that the "front door" to behavioral health treatment is family-friendly and can guide parents/caregivers to get help for their child
- Requiring new **Community Behavioral Health Centers** to deliver goal-oriented, trauma-informed, **evidence-based practices** specific to children, youth, and families
- Increasing capacity for **specialized services for children and youth**, including youth with **autism spectrum disorder or intellectual/developmental disability** (e.g., increased consultation, training, and specialized inpatient treatment beds) and for children in the **care and custody of the Commonwealth** (e.g., clear pathways to behavioral health treatment for kids in care and custody of DCF)
- Expanding acute treatment options for youth by adding **Community Crisis Stabilization** (intensive, short-term stabilization) to existing **Community-Based Acute Treatment** and **Inpatient** levels of care
- Addressing the **impact of the COVID pandemic on the availability of inpatient psychiatric services for youth** by providing additional funding incentives for new inpatient bed capacity for children and youth

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IV. COVID-Related Changes in Federal Law Governing Dependent Care Assistance Plans (DCAPs) (UPDATE)

Matthew Veno, Executive Director

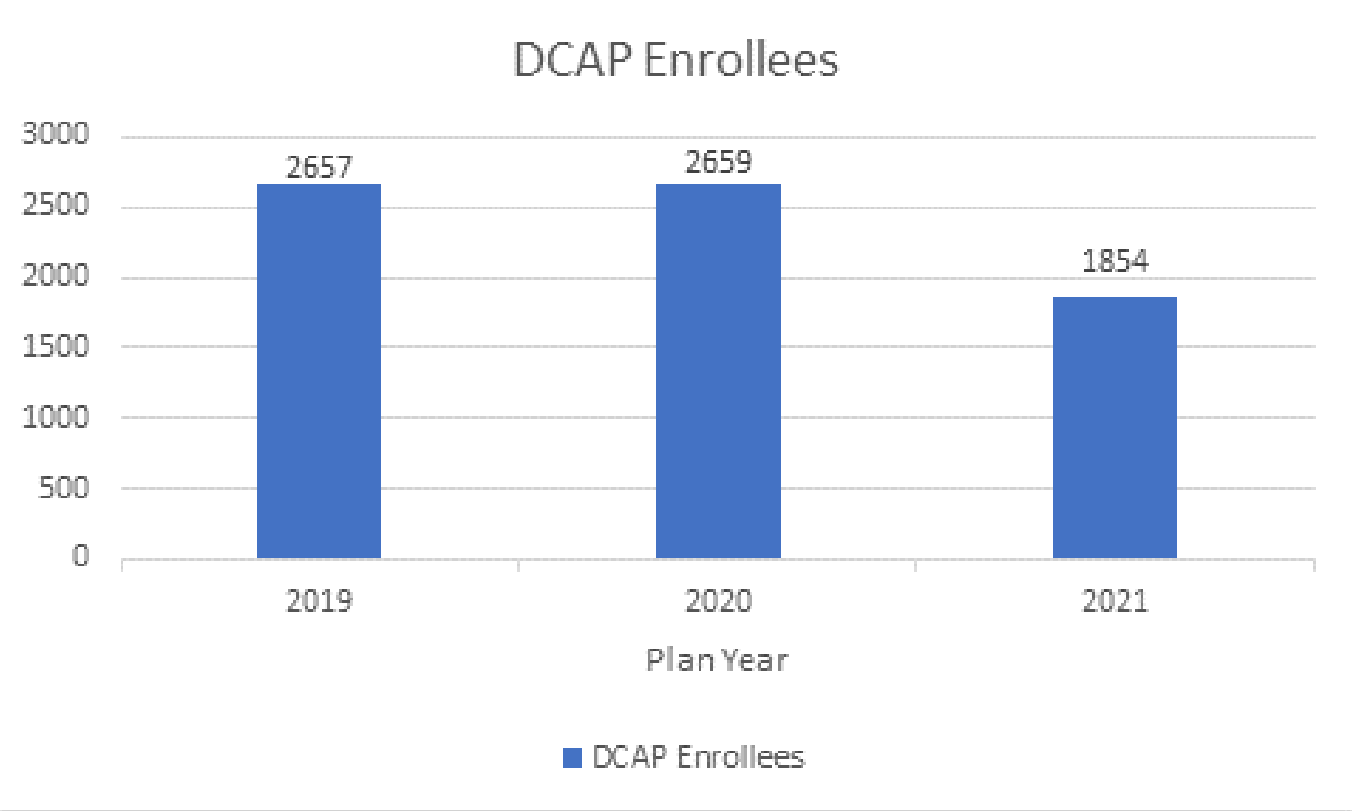
&

Cameron McBean, Manager,

Health & Ancillary Benefits

Dependent Care Assistance Plan (DCAP) Background

- The GIC offers a Dependent Care Assistance Plan (DCAP) which allows members to pay for qualifying expenses for care of eligible dependents on a tax advantaged basis up to the federally prescribed maximum benefit amount.
- Common DCAP expenses include day care, after-school programs, summer camps, and adult/elder care program



Federal Legislative Action

Due to COVID-19's effect on work schedules, and school and day care closures, the federal government identified a risk that many Americans may not be able to utilize their DCAP account balances, resulting in forfeitures.

- **The Consolidated Appropriations Act (CAA) and The American Rescue Plan Act (ARPA),** allow plan sponsors to make the following changes:

1. Allow members to change FSA elections at any time, for any reason, for plan years ending in 2021
2. Extend grace periods or carryover to the end of 2021 and/or 2022
3. Increase the DCAP *contribution* limit to $10,500* but for calendar year 2021 only

- *Reimbursements* greater than $10,500 (due to carryovers and extended grace periods) in CY2021 must be included in taxable income, under current guidance
- The increased exclusion amount will not apply to reimbursement of expenses incurred during the 2022 portion of the plan year (for GIC January-June 2022)
- As of January 2022, the contribution limit reverts back to $5,000, and reimbursements over $5,000 in CY2022 must be included in taxable income, under current guidance

*For those filing as married/joint. $5,250 if filing single/separate.

GIC DCAP Relief Measures Implemented To Date

- The GIC has taken advantage of federal flexibility recently afforded to plan sponsors, and taken steps focused on mitigating the risk that members will forfeit unexpended balances.
  - Extended the grace period to the maximum allowed for members to incur reimbursable expenses for FY2020 by one year, to June 30, 2021.

Key DCAP FSA Dates		
	FY 2020	**FY 2021**
Plan Year:	July 1, 2019 – June 30, 2020	July 1, 2020 – June 30, 2021
Grace Period:	July 1, 2020 – June 30, 2021	July 1, 2021 – September 15, 2021
Claim Filing Deadline:	July 31, 2021	October 15, 2021

  - Relaxed guidelines for qualifying events to allow members additional opportunities to change elected contribution amounts, thereby reducing the likelihood of unused balances

Many GIC members have availed themselves of these options and modified their contribution amounts for plan year 2021, indicating an awareness of DCAP limitations and how COVID impacts them.

Considerations Regarding Increasing DCAP Contribution Limits

1. Recent IRS guidance underscores the complexity of the overlapping laws and regulations and the potential for negative tax consequences for members enrolled in non-calendar year plans

2. There is a substantial risk that GIC member DCAP expenditures in calendar year 2022 will not be not compliant

3. The GIC, as a plan sponsor, could be at compliance risk if the plan is not administered in accordance with law and guidance

4. Adopting a higher limit would require mid-year election changes, which introduces significant administrative complexity

5. Extended grace periods cause DCAP years to overlap, already increasing the likelihood of member confusion

Next Steps

1. The GIC will increase the FY2021 Grace Period from 2.5 months to 6 months (July 1, 2021 – December 31, 2021), and consider further extensions as circumstances suggest are necessary (a vote of the Commission is not required)

2. Actively monitor developments at the federal level, including any additional guidance issued by the IRS that may impact DCAP limits or plan provisions

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V. Provider Prices as Central Driver of Premium Increases (INFORM)

- Contextual Overview
- Attempted Strategies to Address

Matthew Veno, Executive Director
&
Margaret Anshutz, Manager,
Healthcare Analytics

Rising health care costs – it's the prices

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Total Cost = Price x Utilization

Price

- Market Leverage
- Provider consolidation
- Geographic footprint
- Brand reputation
- Innovation and medical advances

Utilization

- Provider driven
- Fee for service rewards volume
- High tech utilization ↑ margin
- Patient driven
- Direct to patient marketing

A National Problem:
Provider Prices, Not Utilization, Drive Rising Health Spending

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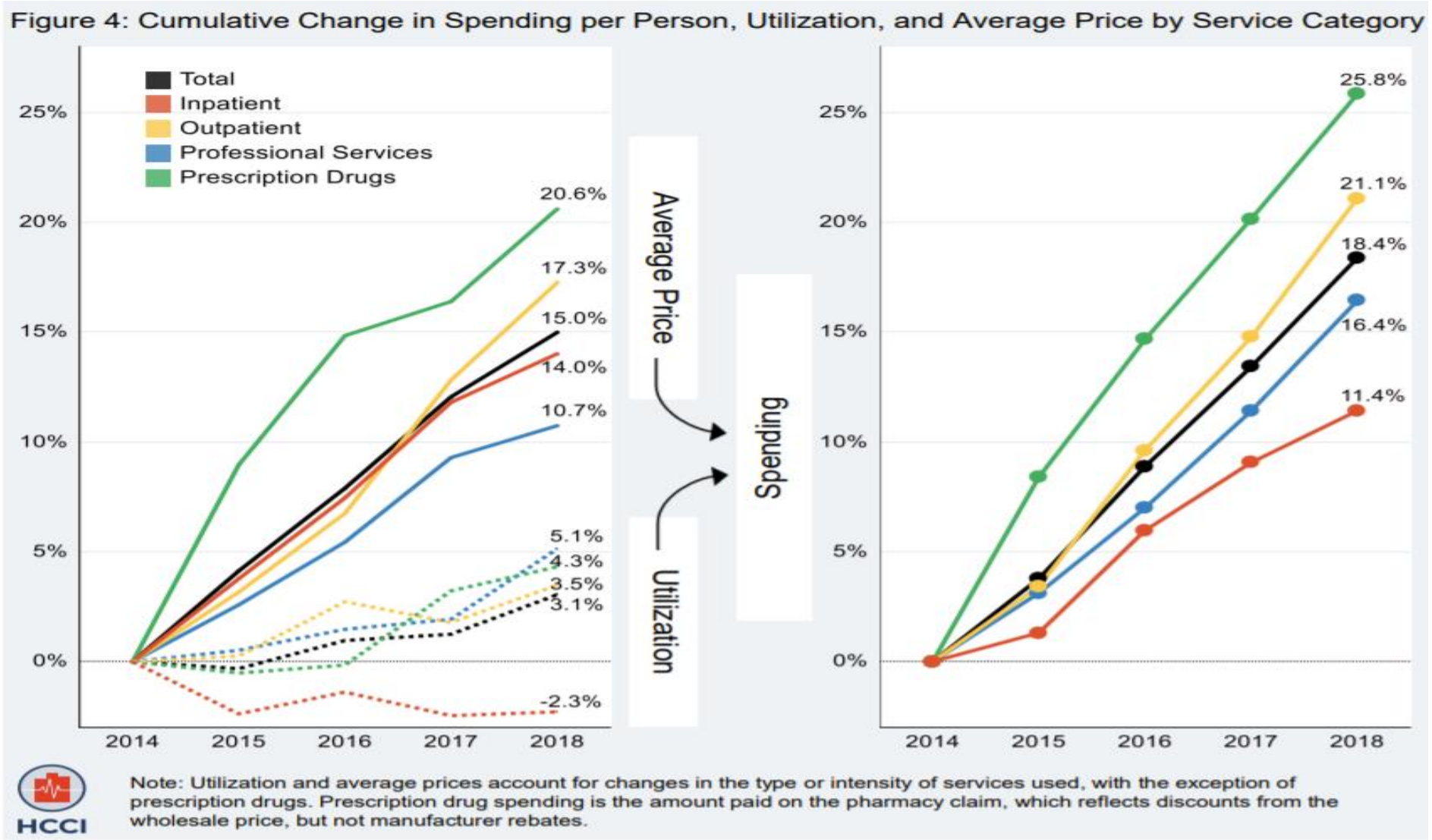

- Utilization increased 3.1% between 2014 and 2018
- Average prices increased 15% between 2014 and 2018

Source: Health Care Cost Institute, 2020

A National Problem:
Provider Prices, Not Utilization, Drives Rising Health Spending

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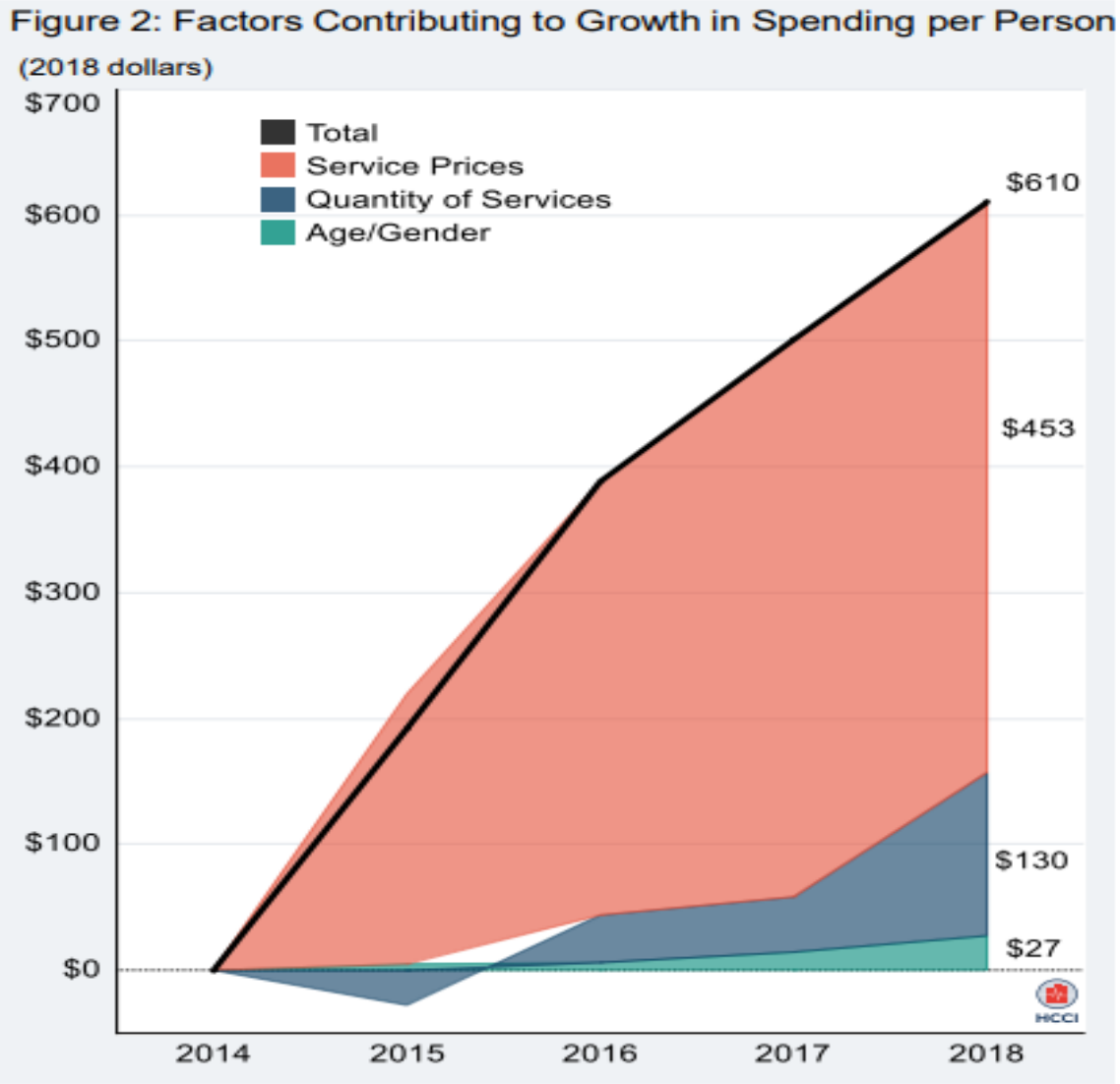

2003

HEALTH SPENDING

It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and Development (OECD). In that first report, featuring 1984 data, the United States

2019

By Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan

It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt

ABSTRACT **A 2003 article titled "It's the Prices, Stupid," and coauthored by the three of us and the recently deceased Uwe Reinhardt found that the sizable differences in health spending between the US and other countries were explained mainly by health care prices. As a tribute to him, we used Organization for Economic Cooperation and Development (OECD) Health Statistics to update these analyses and review critiques of**

A Decade of Data in Massachusetts

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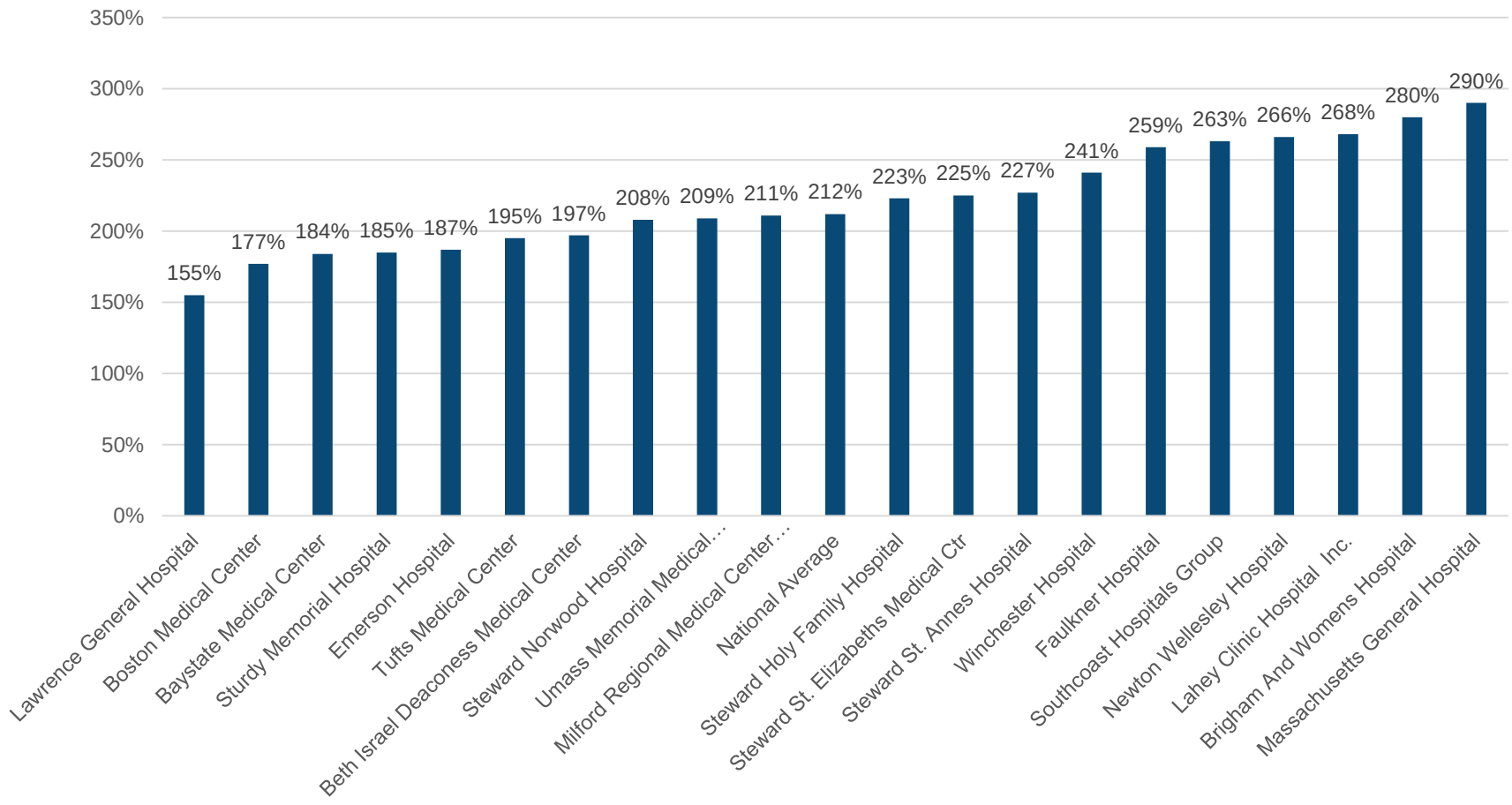
- Wide variation in prices persists with no correlation to quality.
- Providers with the highest Medicare/Medicaid percentage have the lowest commercial prices.
- Massachusetts consumers use high-cost providers more than in other states, and the percentage is growing.

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

Market share captured by high price systems

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Acute Hospital Commercial S-RP and Share of Payments, 2017

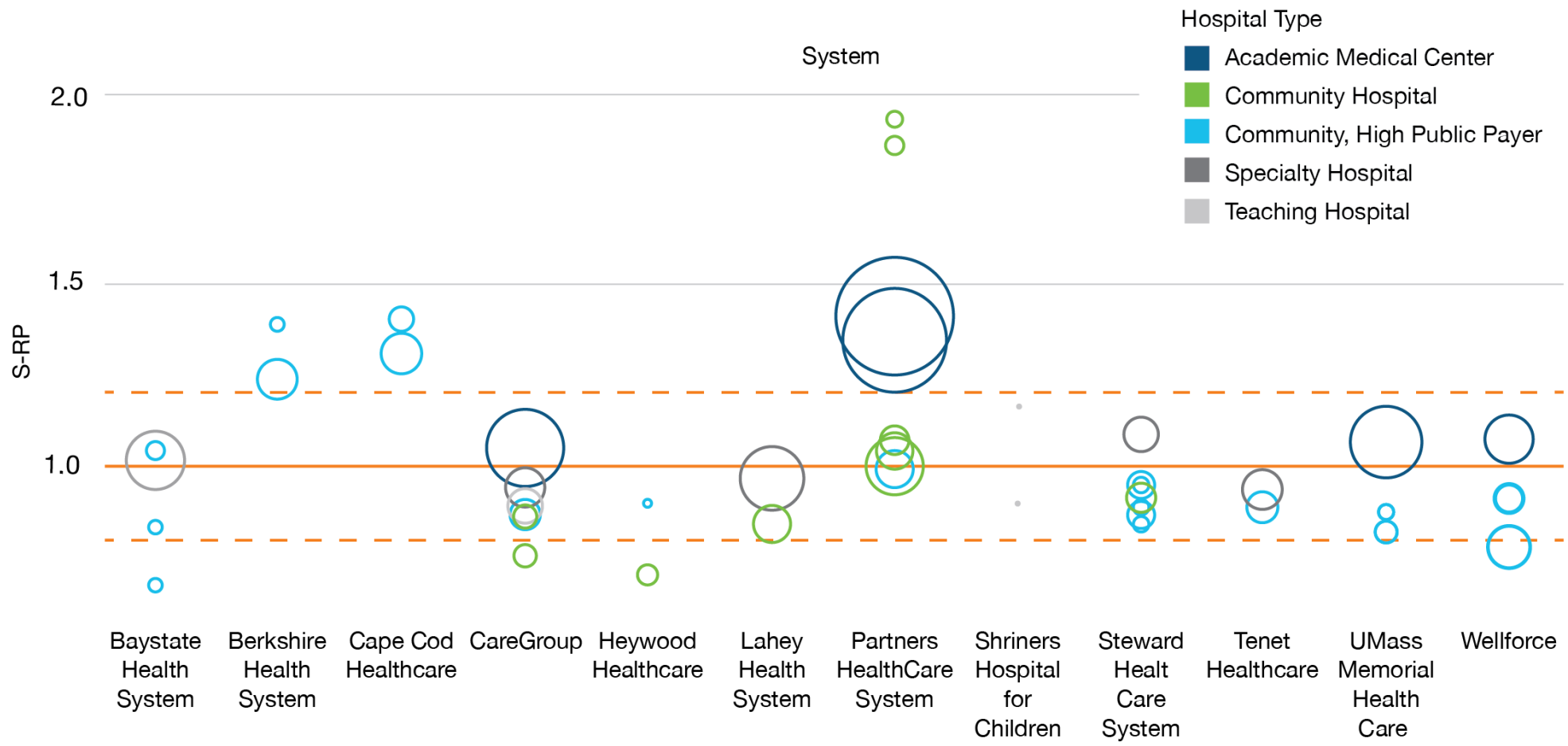

Chart Source: CHIA

Example: Massachusetts Endoscopy snapshot

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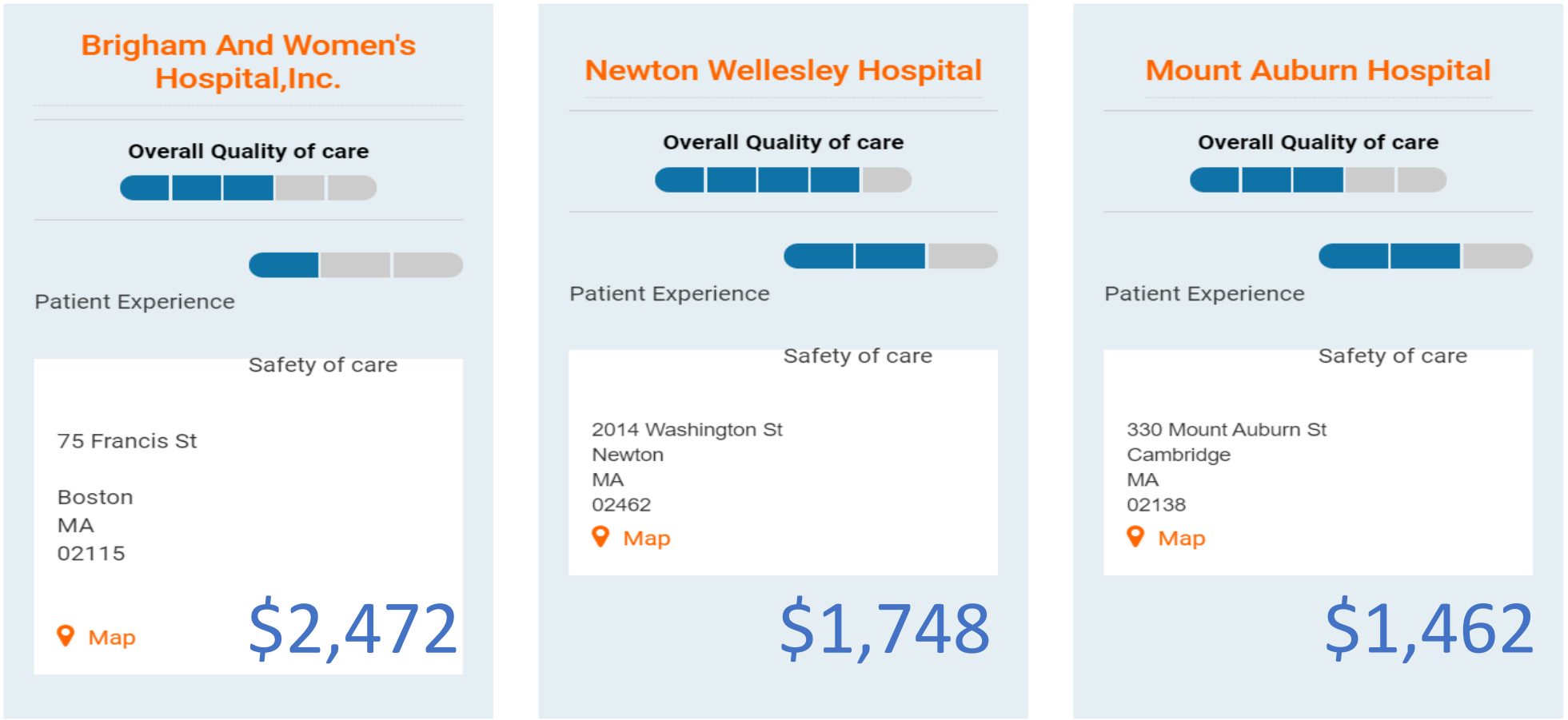
CompareCare
A TRUSTED SERVICE OF THE COMMONWEALTH OF MASSACHUSETTS

Compare Treatment Costs | Get Quality Care | Ask Informed Questions | Troubleshoot an Issue



Source: MassCompareCare.gov/cost/procedure/endoscopy-43239, retrieved 5/7/2021

Price is not strongly correlated with quality

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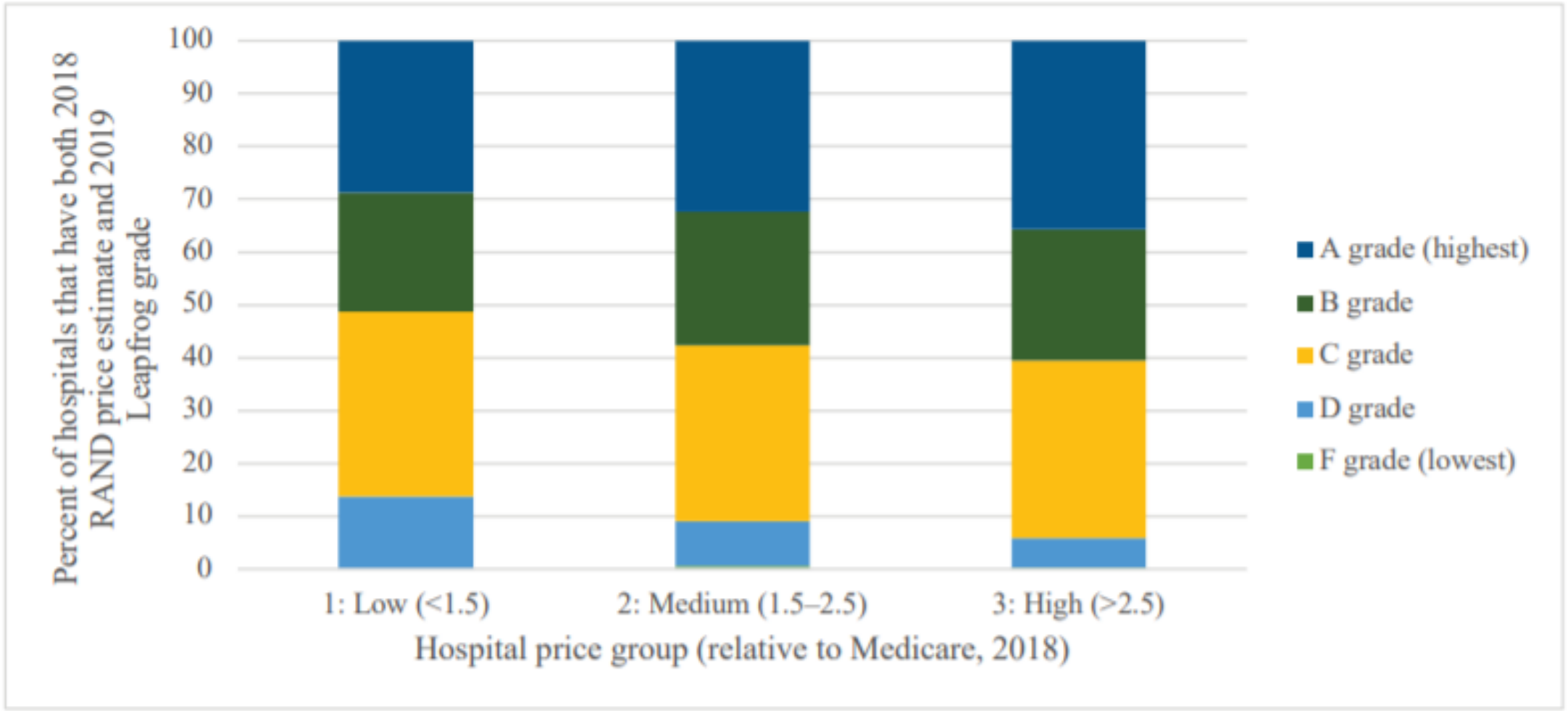
Leapfrog grade unrelated to hospital pricing



Source; RAND, 2020 LINK

No health plan has critical mass to demand lower prices from high-leverage systems

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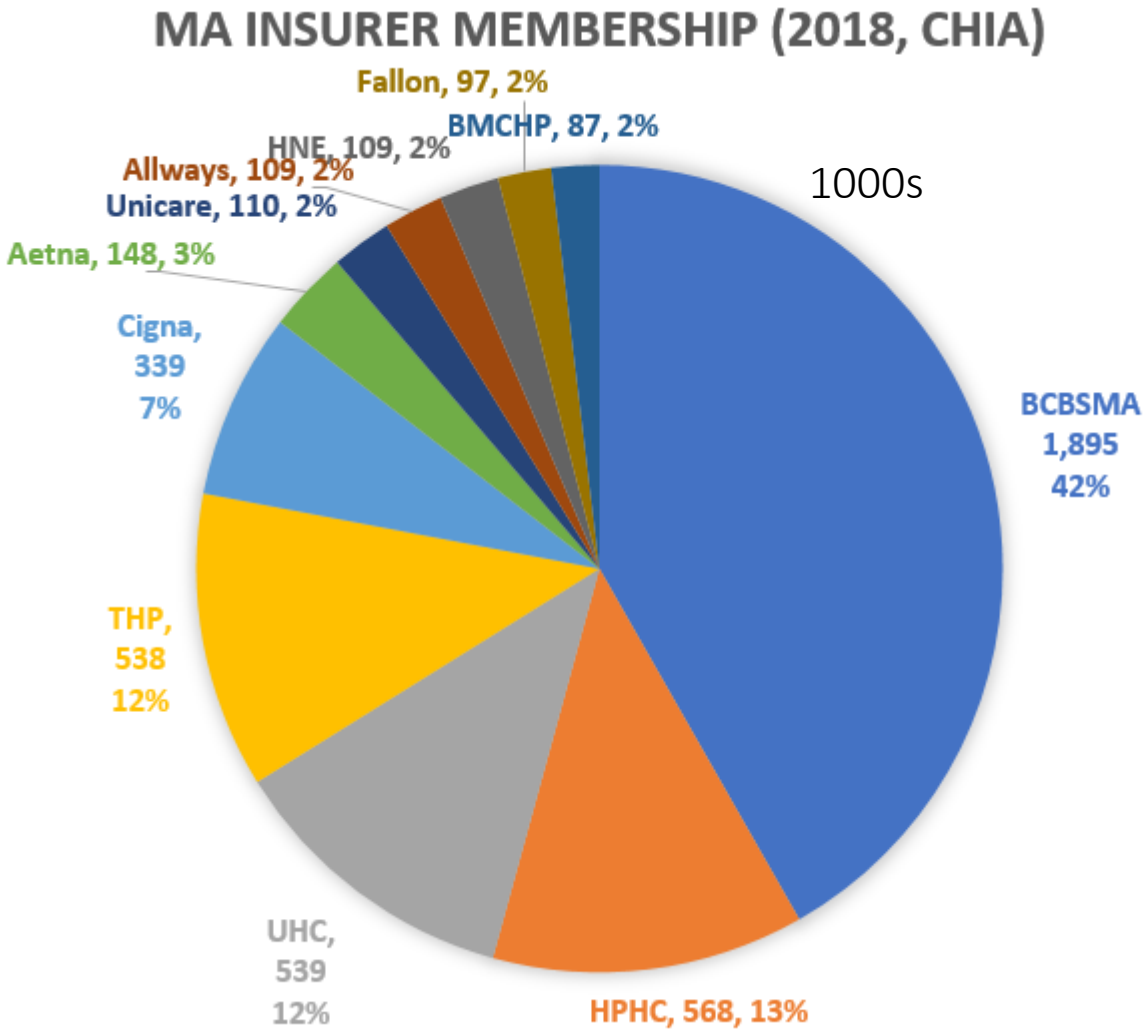

- Even combination of HPHC and Tufts has only 25% of the market
- This represents commercial plans only; providers also receive revenue from Medicare and Medicaid

Source: CHIA 2019 Annual Report LINK

Impact on Value for Members

Rising provider prices → Rising member premiums

Higher premiums, but not better coverage

Impact on Health Equity for Members

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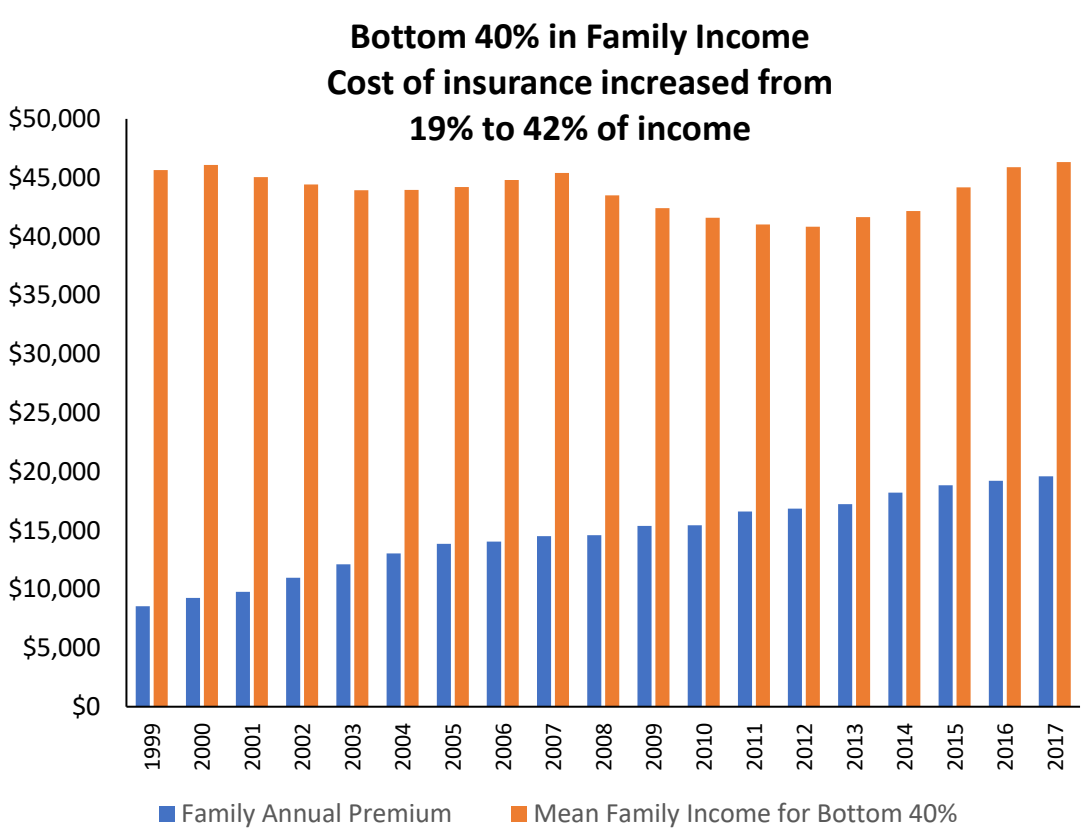
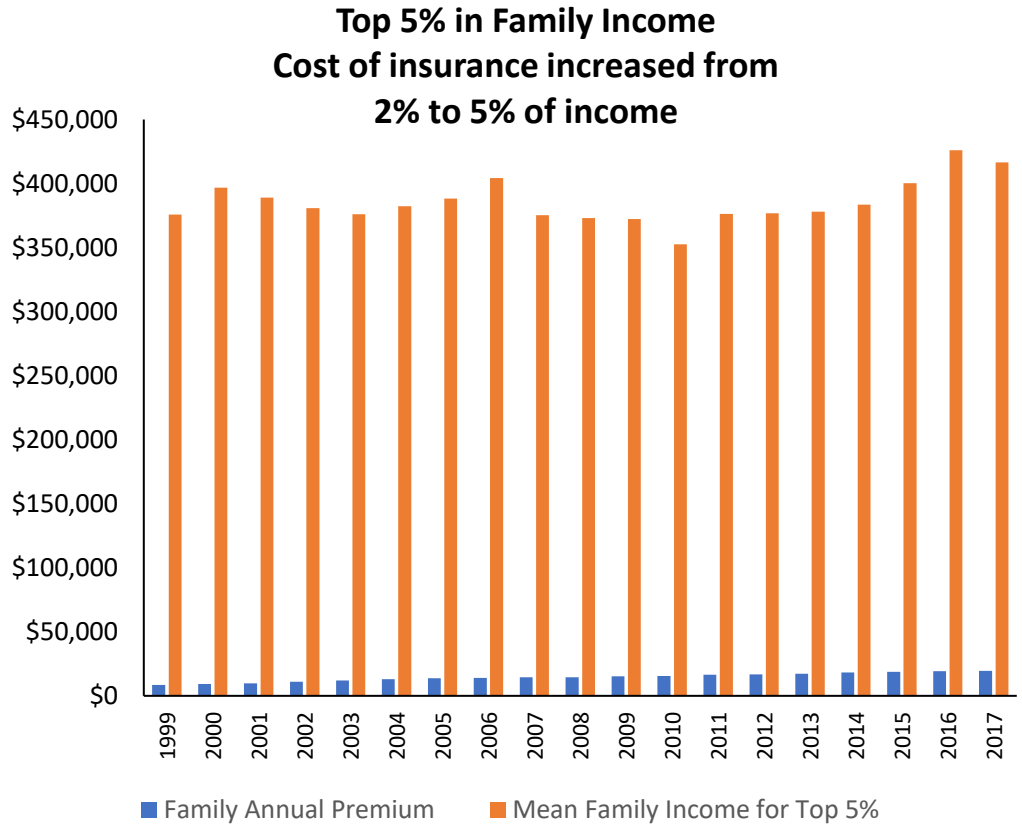
- Providers in low-income communities are paid markedly less than those in affluent communities.
- Yet consumers are paying the same premium regardless of whether they live in a low-income or affluent community.

In the commercial market, consumers in lower-income communities, with higher health care needs, are subsidizing those in higher-income communities, with lower health care needs.

Impact on Health Equity for Members

Unfortunately, income increases have not matched the pace of the cost of insurance – an impact felt most significantly by lower wage families





Health insurance costs from KFF-HRET 2017, and census data is from table F3 of https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-income-families.html All dollars inflation adjusted to 2017

Strategies Attempted

Strategy	GIC	Others
Broad Market Oversight		☑
Consumer Incentives, Tools, & Information	☑	☑
Alternative Payment Methods	☑	☑
Direct Constraint of Provider Prices		☑
Plan Consolidation	☑	
Plan Design	☑	☑

Key Takeaways

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- Prices paid to health care providers vary widely, not due to variable quality but market dysfunction due to market power.
- Rising provider prices, not rising utilization, is the primary driver of increasing health care costs, and therefore premiums.
- Higher overall costs are an especially large threat to lower wage workers, where premium and out-of-pocket costs represent a larger portion of total income.
- A variety of strategies have been implemented to address provider prices, by the GIC and others, with mixed success.

To deliver benefits that are affordable to members and taxpayers, in an equitable fashion, the GIC must employ strategies that address this central challenge in a meaningful way.

V. Cost Drivers (INFORM)

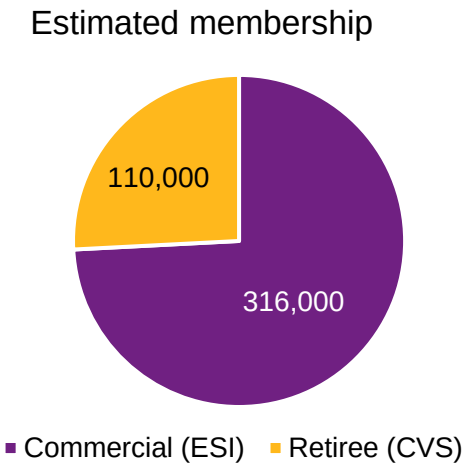
- Prescription Drugs

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



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

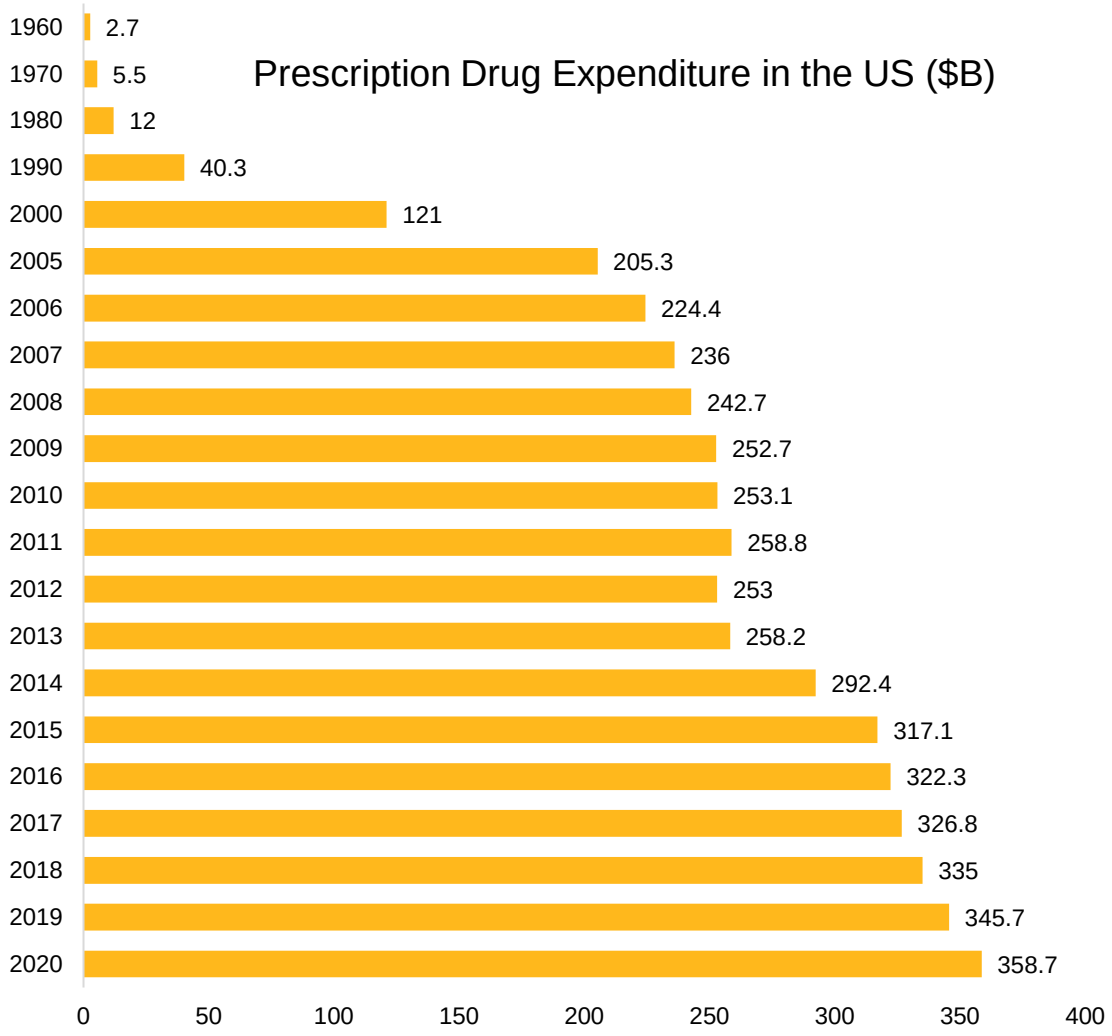
Financial

- 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/

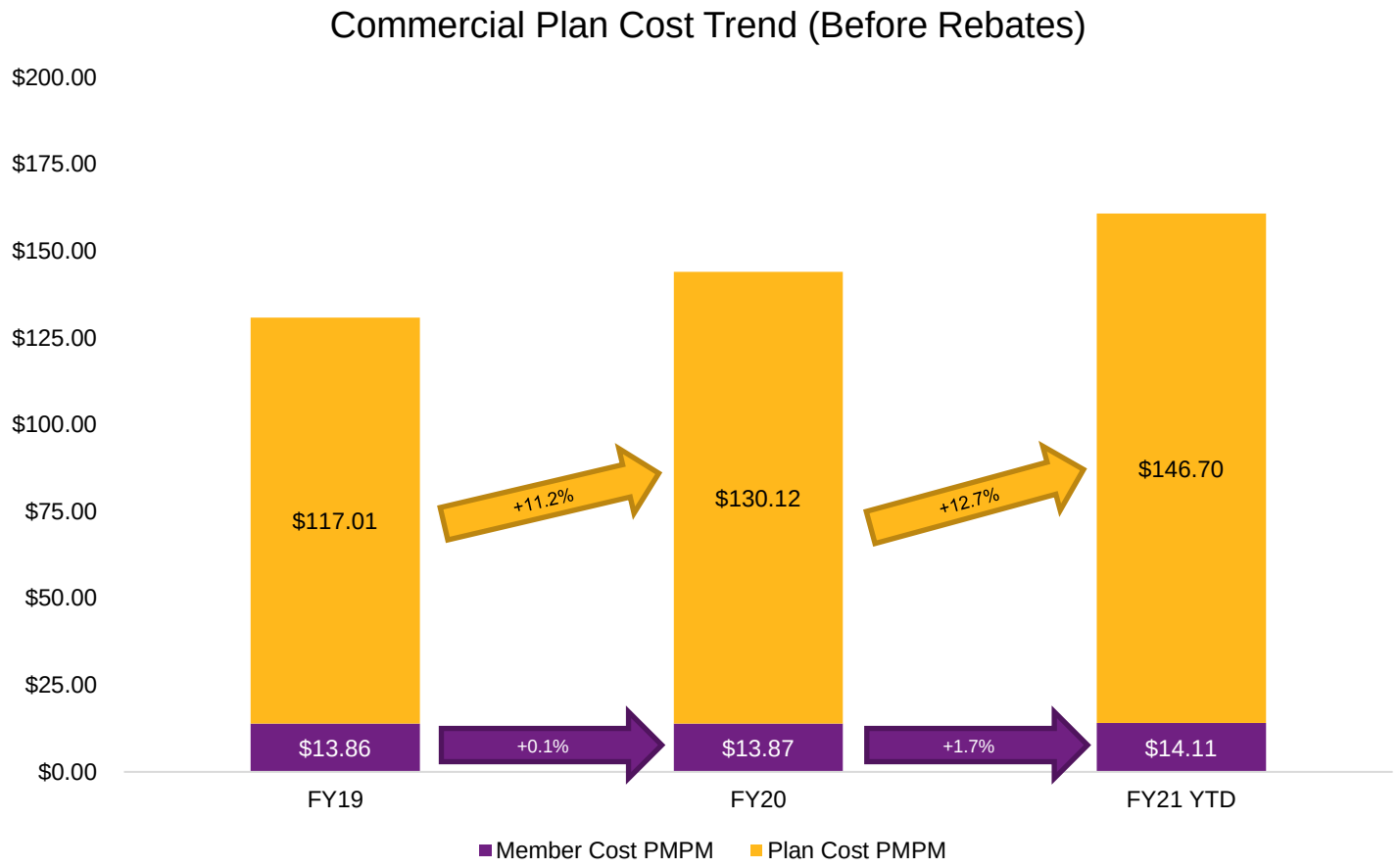
Key Insights

- 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

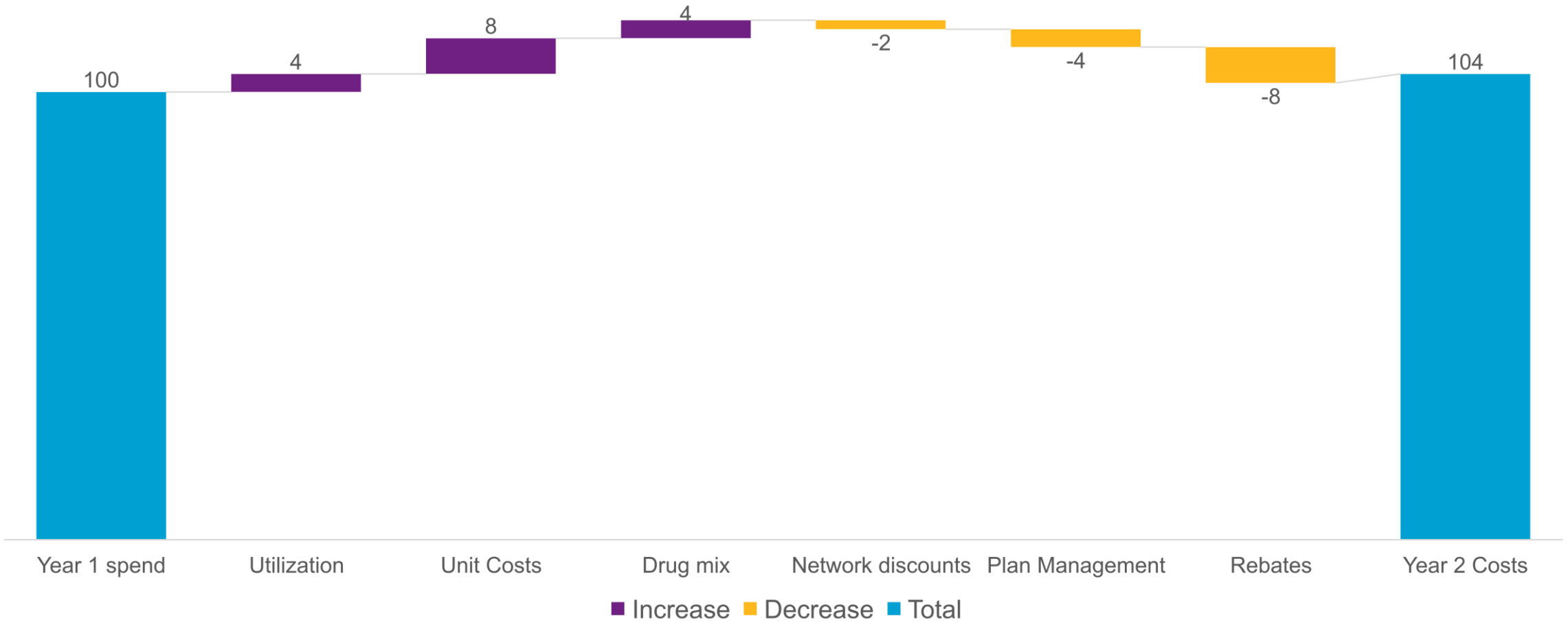
How does the GIC combat high drug costs and ensure the best value for the state and its members?

- 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

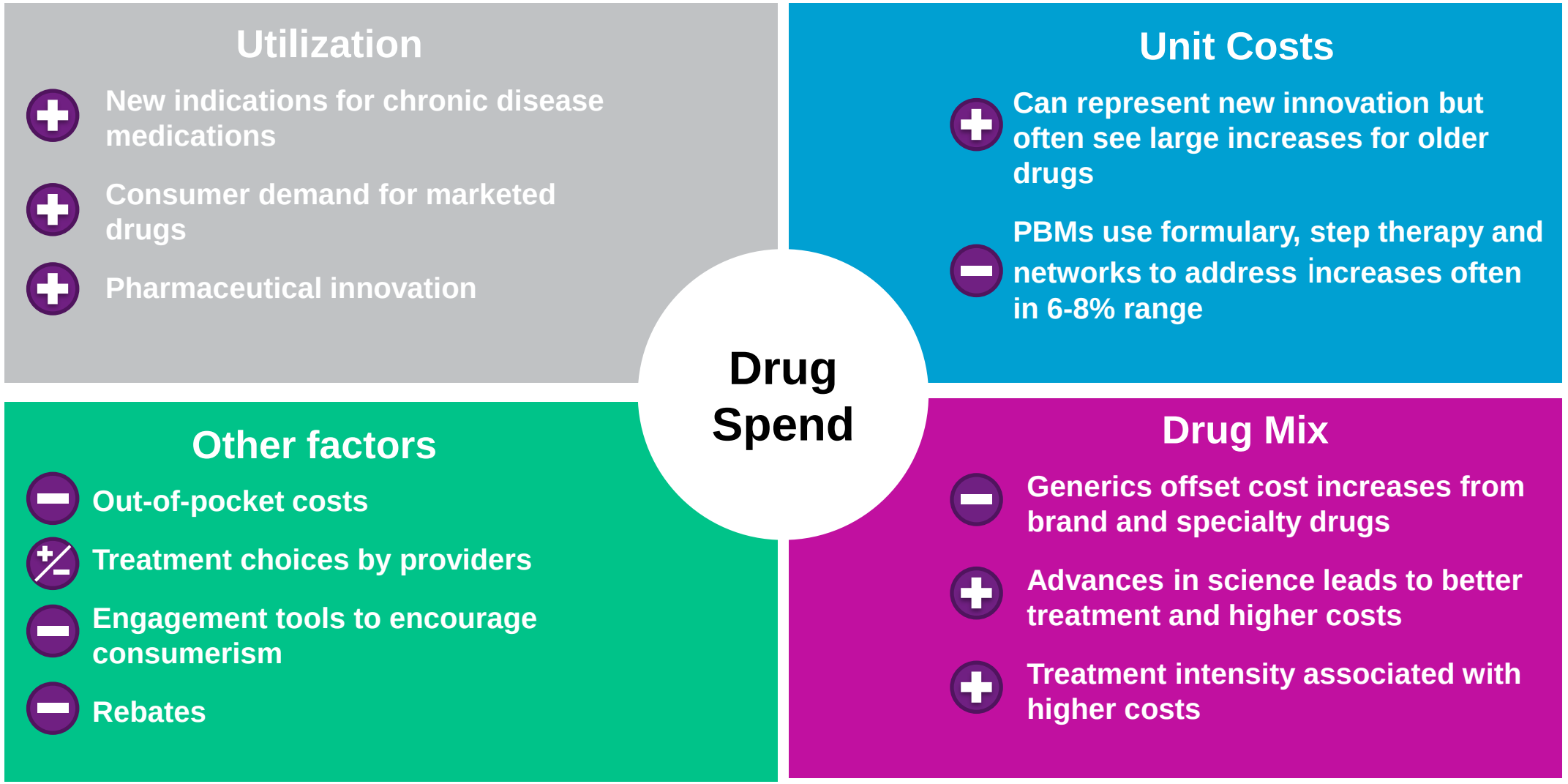
What are the components of pharmacy trend?

Illustrative Example

Pharmacy cost is influenced by increasing and decreasing cost factors



Factors that Influence Drug Trend

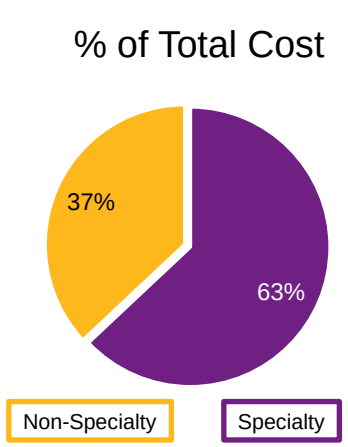


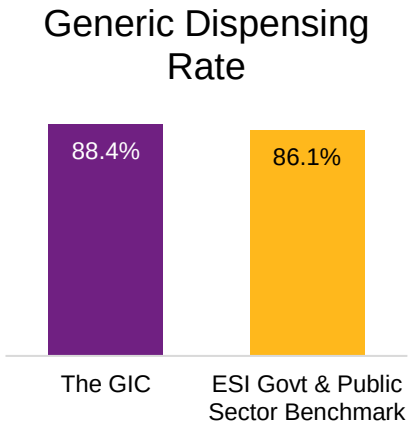
Drug Mix: Cost and Utilization

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

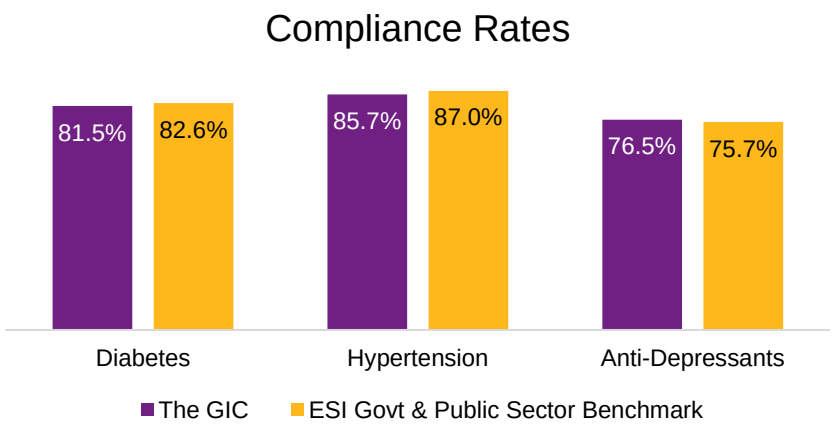
Key Performance Metrics – Commercial (ESI)

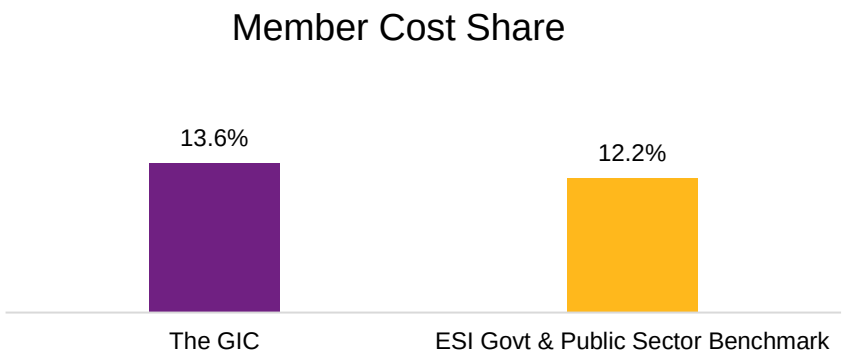




Key Insights

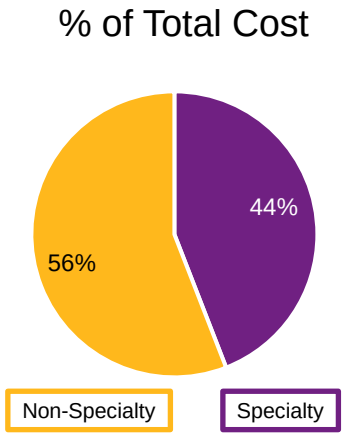
- Specialty spend represents a gross (before rebates) trend of 11.9% driven primarily by increased utilization
- Member share consistent with other large Government peers and lower than private employers (typically in the 15-20% range)
- Higher generic dispensing rate validates efficiency of the plan 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

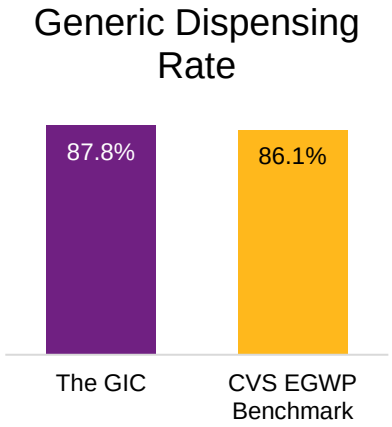




Data based on ESI reporting FY2020 compared to FY2019

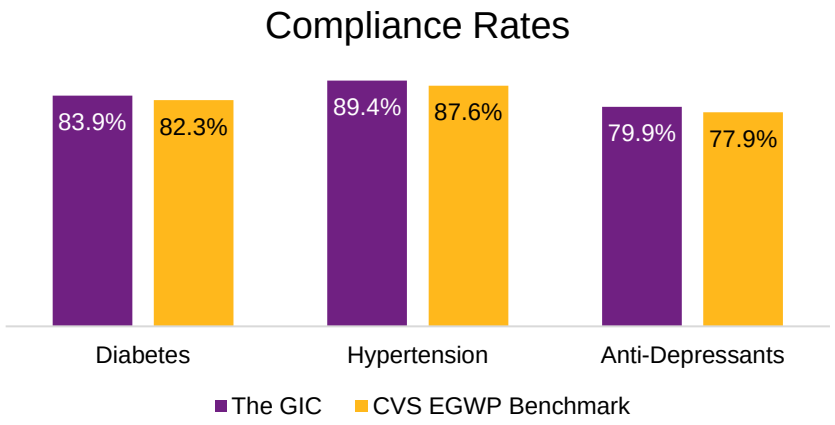
Key Performance Metrics – Medicare (CVS)

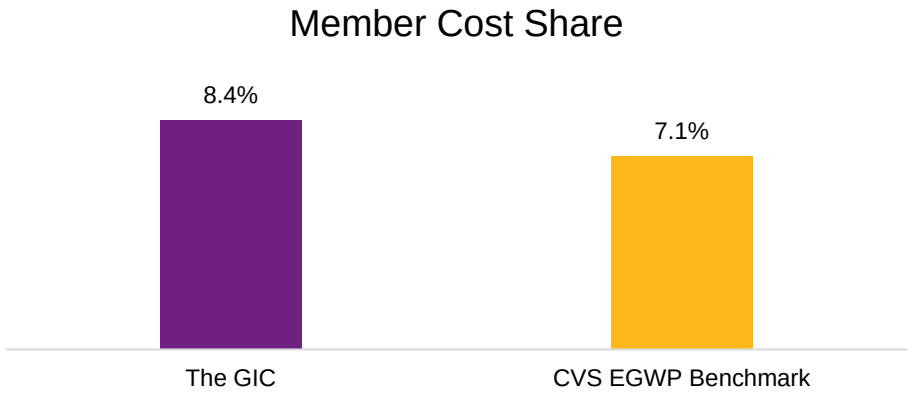




Key Insights

- 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

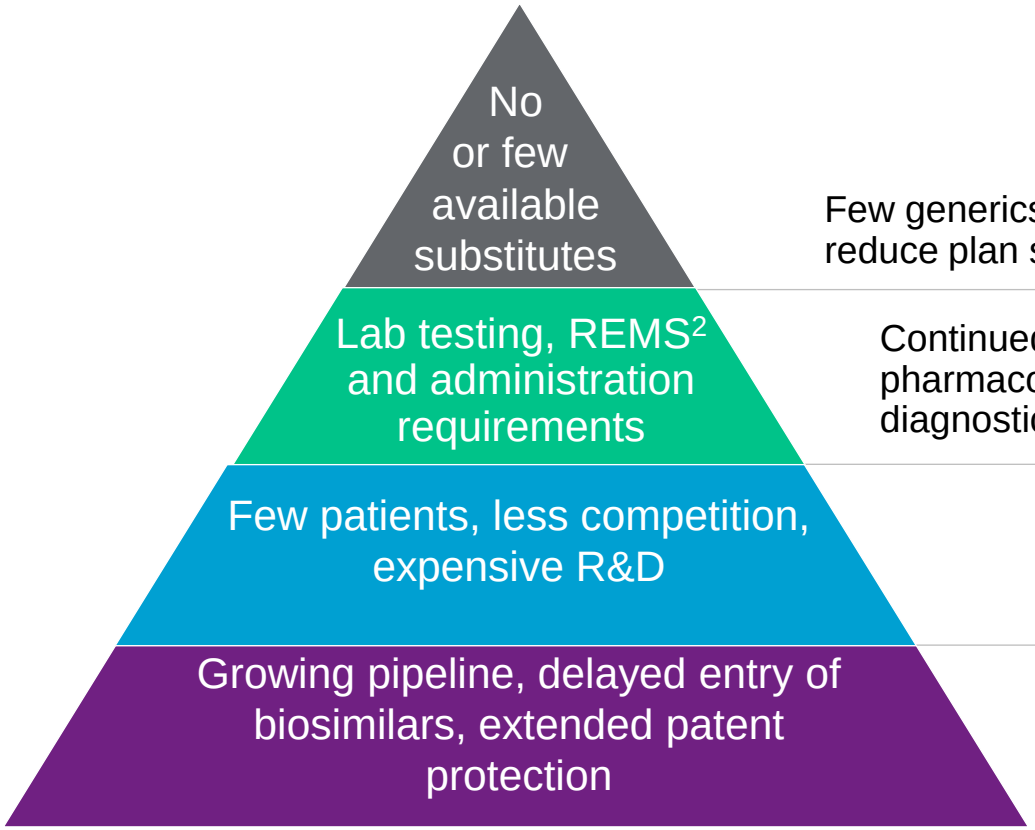




Data based on CVS reporting CY2020 compared to CY2019. Benchmark represents CVS' EGWP book of business

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

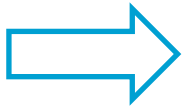
Pipeline includes ‘me too’ therapies as well as $1M+ gene therapies. Relatively few biosimilars are on the market today and biosimilar market launches are slow when a patent finally expires

[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

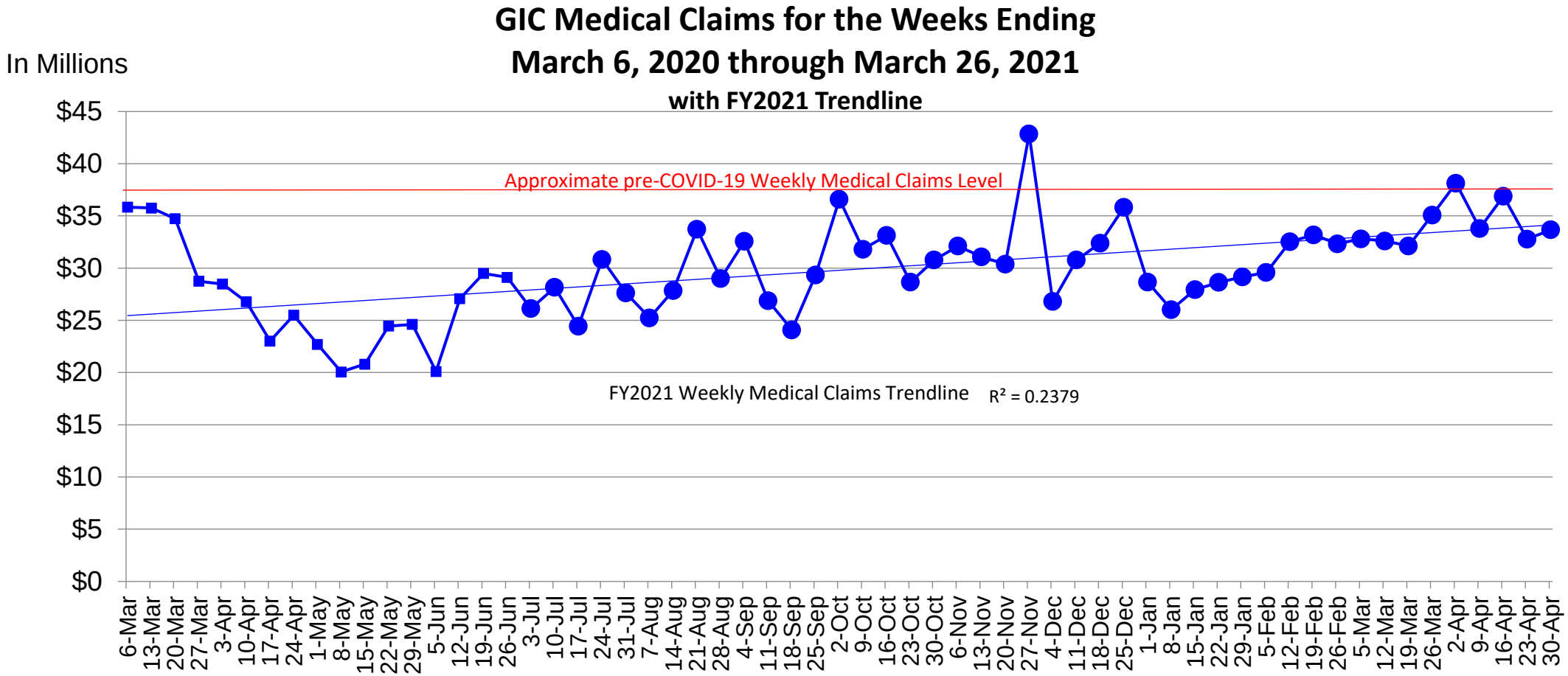
VI. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

- COVID claims update
- FY21 spending to date

Jim Rust, Chief Financial Officer

VI. **CFO UPDATE (INFORM)**



VI. **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	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	$58,880,913
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	$348,485,094
Davis Vision Claims	$25,904	$29,880	$29,661	$20,931	$35,496	$46,593	$28,040	$29,219	$34,008	$36,570	$316,302
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	$52,613,834
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	$288,708,782
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	$68,175,929
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	$305,826,466
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	$35,303,853
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	$540,684,329
Other costs	$32,116	$1,342,358	$740,820	$144,433	$789,999	$258,467	$49,532	$436,301	$191,938	$529,223	$4,515,188
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	$1,703,510,689
Basic Life	$830,652	$831,801	$828,111	$828,290	$827,544	$826,290	$825,235	$824,571	$822,437	$804,050	$8,248,981
Optional Life	$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	$469,779
Long-Term Disability	$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	$7,137,060
Tufts Medicare Preferred	$669,376	$669,824	$672,766	$678,415	$681,629	$680,491	$904,025	$679,698	$680,687	$679,203	$6,996,113
UBH Optum	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$111,384	$94,384	$102,884	$1,088,340
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	$67,242,832
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	$91,183,105
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	$1,794,693,794

- April and March medical claims reflect a return to pre COVID-19 levels
- Medical claims volume was significantly lower in January and February, reflecting a reduction of utilization during the December COVID-19 surge

VI. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

FY21 STATE SHARE EXPENSE FOR GIC PREMIUM ACCOUNTS											
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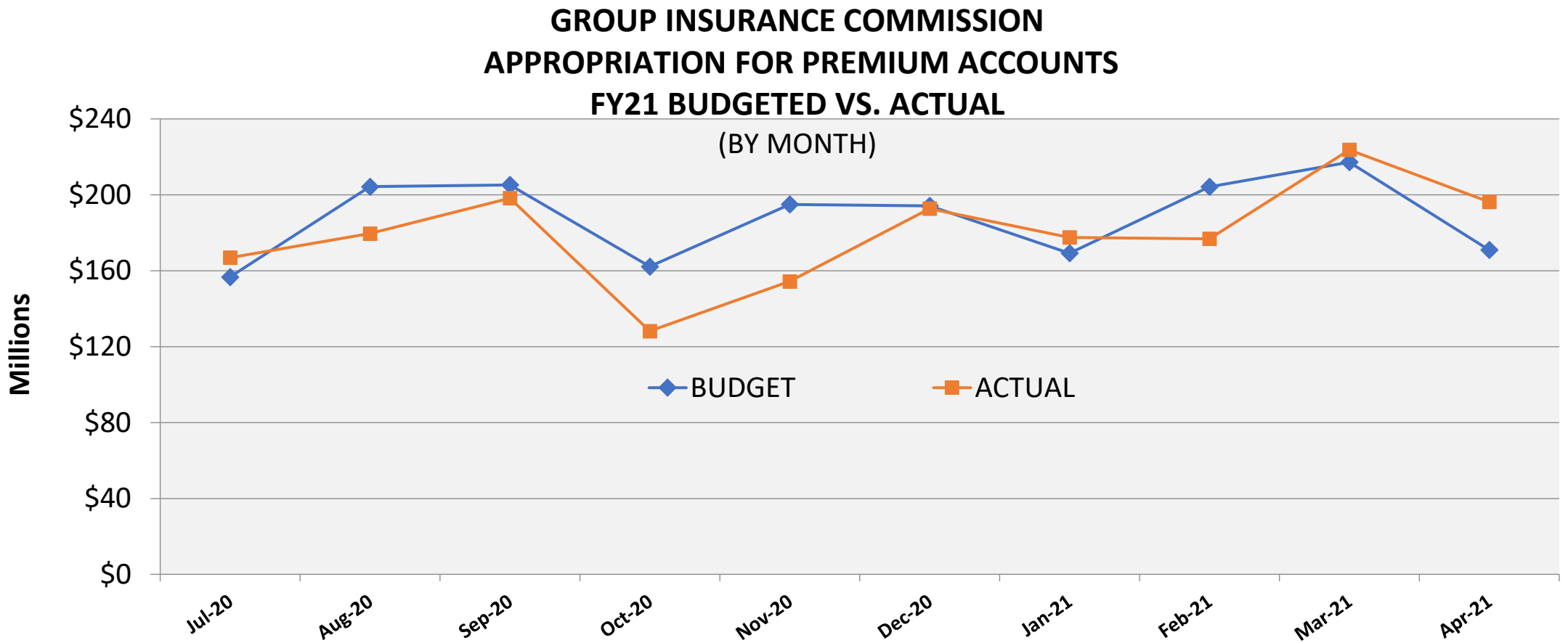
- As expected, enrollee share paid claims have an identical pattern

VI. **CFO UPDATE (INFORM)**



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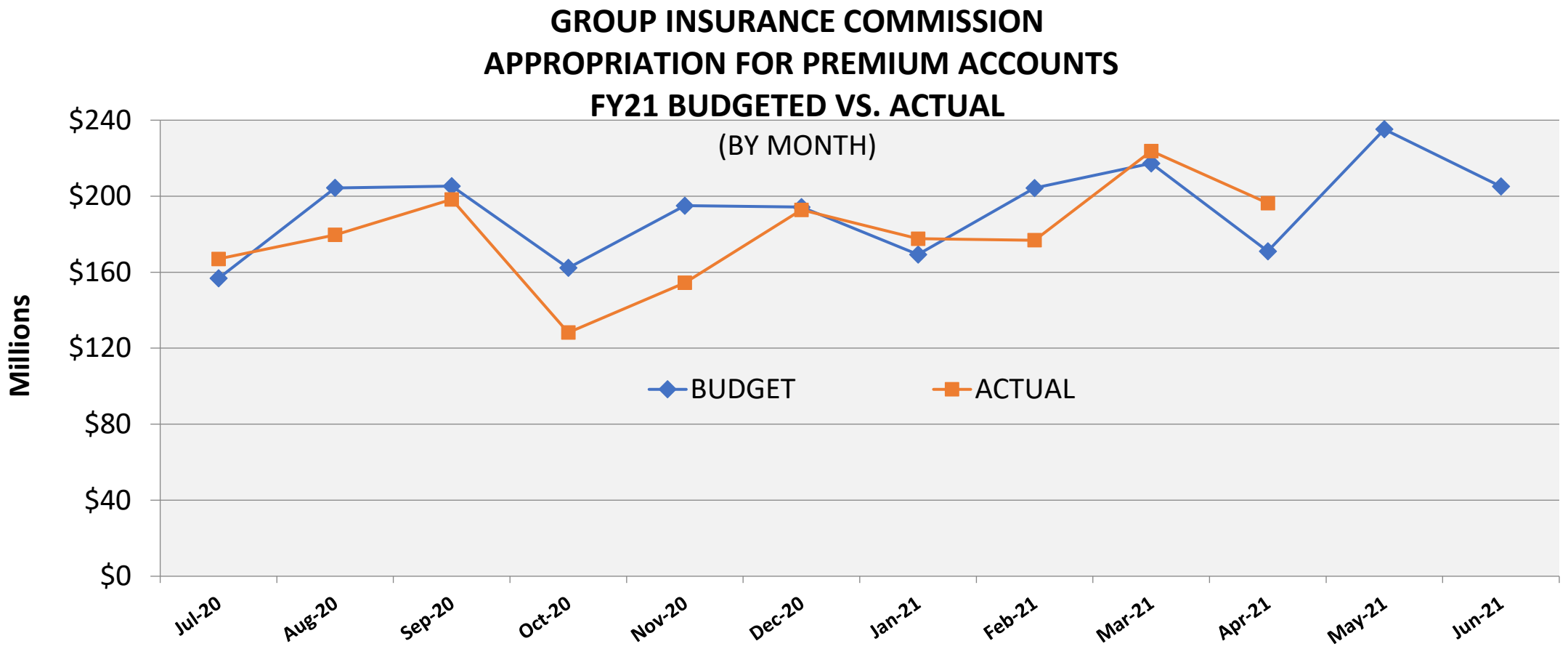
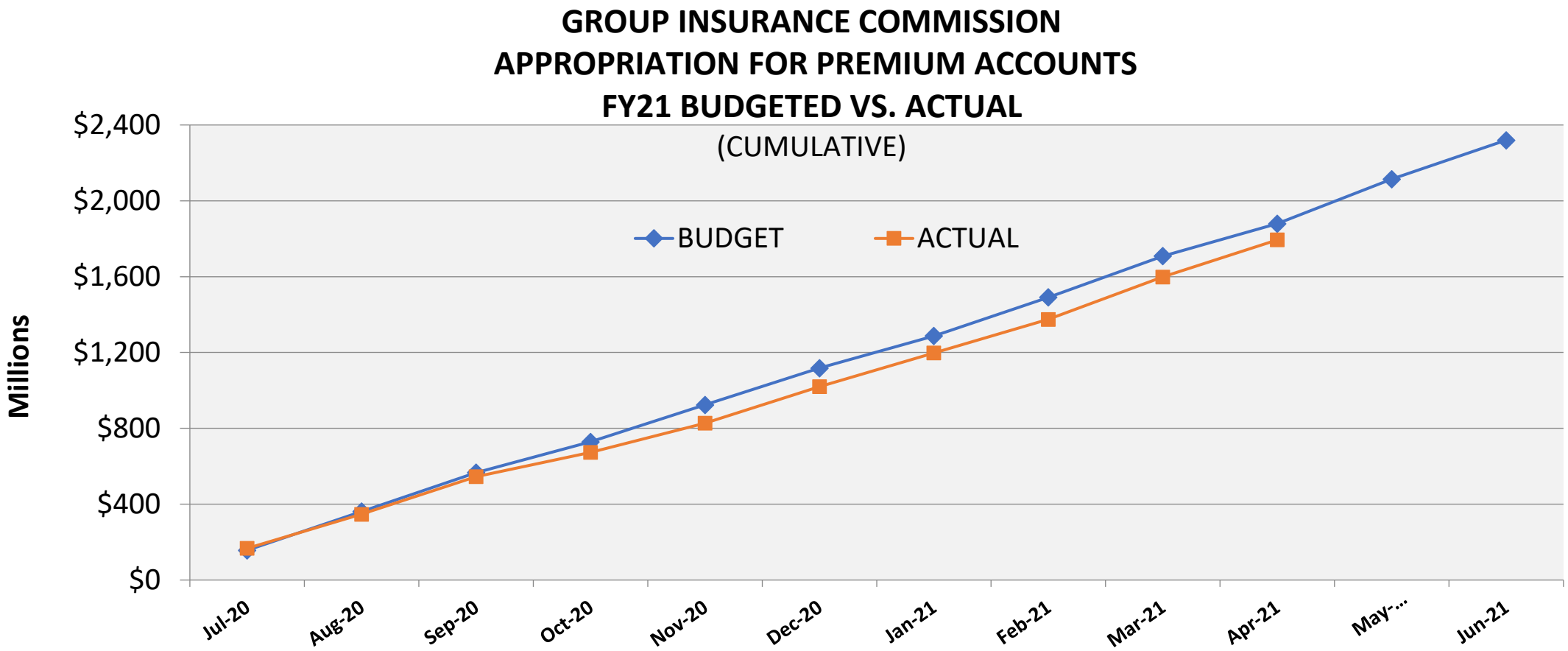
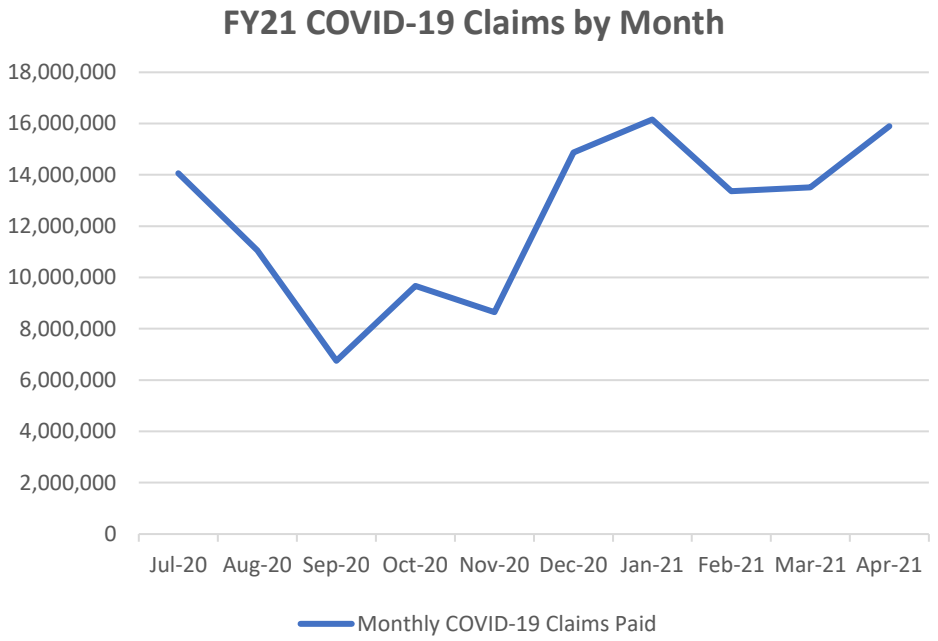


VI. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection



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
Total FY21 COVID-19 Claims to Date		123,985,178
Total FY20 COVID-19 Claims		43,361,207
Total COVID-19 Claims FY20 & FY21		167,346,385

- COVID-19 related claims were high during the Feb-April period although total medical claims were lower during Feb - March
  - Given the 4-6 week claims lag, this suggests utilization of non-urgent medial care was impacted by the increase in COVID-19 cases after the holiday season through December and January
  - Both medical and COVID-19 claims were substantial in April

VI. **CFO UPDATE (INFORM)**

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

FY21 STATE SHARE PREMIUM BUDGET FOR GIC PREMIUM ACCOUNTS AS OF APRIL 30, 2021				
	BUDGET	**EXPENSES**	**Surplus / Deficit**	**% VAR**
Basic Life & Health **Account #1108-5200 & #1599-6152**	$1,871,416,697	$1,787,240,433	$84,176,265	4.5%
Active Dental & Vision Benefits * **Account #1108-5500**	$8,051,988	$7,453,362	$598,626	7.4%
Total State Share YTD	$1,879,468,685	$1,794,693,794	$84,774,891	4.5%

- 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
    - April and March 2021 has 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

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

VII. Other Business/Adjournment

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

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

September 2021

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26	27	28	29	30		

October 2021

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24	25	26	27	28	29	30
31						

November 2021

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21	22	23	24	25	26	27
28	29	30				

December 2021

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26	27	28	29	30	31	

January 2022

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23	24	25	26	27	28	29
30	31					

February 2022

S	M	T	W	T	F	S
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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
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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		

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

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
Group Insurance Commission
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
Your Benefits Connection

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