# GIC COMMISSION MEETING
## Thursday, December 6, 2018
## 8:30 A.M. – 10:30A.M.

Charles F. Hurley Building
19 Staniford Street
Boston, MA 02114

**MINUTES OF THE MEETING**

NUMBER: Six Hundred Forty
DATE: December 6, 2018
TIME: 8:30 AM
PLACE: John W. McCormack Building, Conference Rooms 1&2, 21st Floor, 1 Ashburton Place, Boston, MA 02108

**Members Present:**

VALERIE SULLIVAN (Chair, Public Member)

GARY ANDERSON, (Commissioner of Insurance) Designee Matt Veno

MICHAEL HEFFERNAN (Secretary of ANF) Designee Elizabeth Denniston

ADAM CHAPDELAINE (Town of Arlington--Massachusetts Municipal Association)

THERON R. BRADLEY (Public Member)

EDWARD T. CHOATE (Public Member)

CHRISTINE HAYES CLINARD, ESQ. (Public Member)

TAMARA P. DAVIS (Public Member)

JANE EDMONDS (Retiree)

JOSEPH GENTILE (AFL-CIO, Public Safety Member)

BOBBI KAPLAN (NAGE)

EILEEN P. MCANNENY (Public Member)

ANNA SINAIKO, Ph.D. (Health Economist)

TIMOTHY D. SULLIVAN (Massachusetts Teachers Association)

MARGARET THOMPSON (Local 5000, SEIU, NAGE)

**Not Present:** KEVIN DRAKE (Local 93, Labor)

## I. Approval of Meeting Minutes

The Chair called the meeting to order at 8:33am. The Chair asked if anyone had questions or comments about the minutes from November 1, 2018 before she asked for a motion to approve the minutes. Commissioner Sullivan motioned to approve and Commissioner Edmonds seconded the motion which was unanimously approved, with Designee Denniston abstaining since she was not at the prior meeting.

The Chair then turned the meeting over to the Executive Director for her report.

## II. Director's Report

The Executive Director gave an overview of the agenda, meeting goals, and items that would require a vote.

[, Commissioner Davis arrived at 8:35am.]
The Executive Director provided an update on the Accenture consulting project. She stated it has three components – strategy, business redesign and analytics. She stated that it was going well and that there has been a lot of stakeholder involvement across the Commonwealth. She mentioned that the deliverables would be complete by the end of January and that the Commission will be kept apprised of the recommendations and changes, likely during the January or March Commission meetings. The Executive Director stated that some parts of the project have been implemented already to better position the GIC for open enrollment.

The Executive Director stated that Hopedale, Winchendon, Dracut, and Groton-Dunstable would be leaving GIC coverage and she reviewed the towns, cities, and school districts that were renewing their coverage. She stated that the Bi-County Collaborative (serves 19 school districts in Norfolk County) will be joining the GIC.

Commissioner Kaplan asked why the smaller towns are leaving GIC coverage.

The Executive Director acknowledged that it was for a variety of reasons. She said that the Commission should have a discussion about how the GIC fits into the market, as there are some powerful and effective other channels in the marketplace. She noted that the GIC is an option of last resort. Further, she noted that there's a very unique political situation in each municipality; there may be a difference of opinion of leadership and unions, etc.

Commissioner Chapdelaine agreed with the Executive Director, adding that leaving can depend on rates, plan design, or even how the community offsets out of pocket costs.

Chair Sullivan inquired if any Accenture work is coordinating the municipalities with other agencies. The Executive Director responded that the work potentially is focused on that. She stated that the Accenture work is examining the GIC business models and asking how we work with other agencies and entities, municipalities being one of those entities.

[Commissioner McAnneny arrived at 8:43am.]

The Executive Director then mentioned that the Flexible Spending Account procurement team has completed all finalist interviews and is on track for a January recommendation to the Commission.

Next, the Executive Director gave an update on pharmacy, reminding Commissioners that some pharmacy formulary requirements will be implemented in January. She mentioned that, so far, ESI (Express Scripts, Inc.) has done a great job on implementation. The pended programs focused on brand v. generic differences, moving members to a preferred brand alternative, and prior authorization requirements. The GIC intentionally delayed these for 6 months and expects that, despite the outreach to members regarding these changes, we will receive calls and some members will not have arranged things in time. Additionally, this coincides with standard formulary changes that occur every January. The Commissioners may also hear member complaints around these changes.

The Executive Director mentioned that the GIC has held annual stewardship meetings with all of its vendors (health, life, dental, etc.). These meetings followed outreach to the CEOs during the summer, and the Health Policy Commission's annual fall cost trend hearings. Prior to these meetings, the GIC worked with Willis Towers Watson (WTW) and Optum to look at its book of business and market trends.

[Commissioner Clinard arrived at 8:47am.]

The GIC wanted to understand how each plan felt things were going and how to best collaborate with the GIC. There were some themes throughout the meetings. One theme was around tiering, as there is an acknowledgement that physician led practices not associated with Academic Medical Centers consistently have the lowest costs. The provider contracting landscape continues to be challenging. We discussed member engagement with all the plans, as well, although each plan has their own unique approach to this. The Executive Director noted that the GIC is working to tease out what activities are best managed by the GIC, what should be owned by the plans, and where collaboration will achieve the best results.

The Executive Director noted that cost drivers are fairly consistent, noting that specialty pharmacy is a main driver of costs. She stated that there will be a follow up discussion for the Commission on this topic, at some point.

## III. Health Benefits Update – Willis Towers Watson

The calendar dates for meetings and GIC staff work was presented to the Commission. Commissioner Kaplan asked for the specific date of the third public listening session. The Executive Director noted that the slide presented a date span. The GIC's Chief of Staff stated that she was working with local officials to find the best venue in each area. Commissioner Clinard stated her support for a listening session in Lowell. Commissioner Sullivan voiced support for a session in the south east part of Massachusetts.

The Executive Director reminded the Commissioners that they had seen a heat map of the membership in the previous meeting that was the basis for determining best location for meetings. She also underscored that in off cycle (non-procurement) years, the GIC typically holds only one session in Boston which historically has been sparsely attended.

The Chief of Staff mentioned that the GIC is looking at technological solutions like webinars and pre-taped events, to augment face to face sessions.

The Executive Director stated that the GIC intends for the public dialogue to become an ongoing exchange, not just one that happens on particular dates or once a year. The Executive Director then presented two slides to the Commission that set out the work flow of the GIC, along with other state deadlines to which the GIC is beholden. The first slide was drawn up by the General Counsel and it diagrammed the whole process from state budgeting to rate development, to member feedback, etc. The second slide attempted to codify the General Counsel's handwritten one. Both slides demonstrate the steps the GIC must complete to develop rates with our consultants. It also includes what's required as precursory work before rate development happens and the state budgeting process. The Executive Director mentioned that all of this is necessary to answer the question this Commission asked about why it is difficult to ever have sufficient time for member engagement leading up to rate setting. The Executive Director explained that the GIC must finalize product prices by March 1st in order for annual enrollment to be ready for April 1st; however, the GIC has to wait until November to accumulate enough claims data to perform any forecasting on the rates. The prices are dependent on what benefit decisions are made, which the GIC decides in January. One result, the Executive Director explained, is that the Governor's budget and the GIC's votes on rates are therefore released and made before the final product pricing can be determined.

The Executive Director further explained that actuaries look at forecasting, then GIC staff presents benefit changes in January, and only then can the GIC talk to the public about those proposed changes. Following that, the Commission votes on benefit designs in February and those are applied down to the health plan level then the GIC can (finally) determine pricing. The Executive Director asked if this was helpful for the Commissioners and there was agreement that it was helpful.

Commissioner Sullivan asked how other employers deal with these challenges. Jeff Levin-Scherz, lead consultant for WTW, answered that the GIC is a very unique health plan sponsor and is not exactly like a standard employer. He stated that the GIC covers a large range of people from health needs to financial needs, union and non-union, and have members who perform vastly different types of work. He noted that most companies run this exercise through the HR side with oversight from the CFO and little to no input from employees. Additionally, it's rare that an employer would have more than one carrier per work place or geography, much less the six that are offered by the GIC.

The Executive Director stated that next the Commission would be hearing a health and benefits update and its relationship to rate development. The Commission would then have a chance to discuss benefit designs. She introduced Vince Kane, WTW's Health Plan Lead Financial Consultant and Actuary, to speak about rate development and market trends.

Mr. Kane discussed the health care marketplace first. He noted that WTW performs a best practices (in the marketplace) survey. The survey anticipates what the rates might be over the next couple of years by looking at the marketplace overall and by industry. Mr. Kane stated that for public sector trends of 5-6% are expected. He explained further that the percentage vary depending on whether the richness of benefits is adjusted (benefit buy downs).

Commissioner McAnneny asked if the trend National or specific to MA. Mr. Kane noted that it was national data, even the public sector cohort.

Commissioner Denniston asked what kind of plan changes Mr. Kane was referring to when he spoke about "benefit buy down". Mr. Kane replied that this could include increase of copays, coinsurance, other out of pocket expenses, or it could simply be less coverage.

Commissioner Veno asked if the trend forecast might also include network changes. Mr. Kane stated that it should include network changes. Mr. Kane acknowledged that the overall pricing process is extremely complicated. He explained that WTW collects claims experience from the last complete fiscal year. They try to capture anything that would count towards member costs, which includes but may not be limited to all claims, non-fee-for-service claims charges, pharmacy charges, medical charges, etc. Then, those costs are trended forward, using underwriting models, which look at migration and other changes. WTW gathers current and past GIC census data and forecasts headcounts. Estimates of plan design changes for the upcoming year might be included, if known. Pharmacy Benefit Managers (PBMs) are asked for anticipated changes and trends and cost offsets, like rebates and Employer Group Waiver Program (EGWP) money. Then WTW builds a rate for each plan, which includes administrative fees and anticipated costs of coverage. Based on the rates, WTW recommends a full cost premium for each plan. Based on the full premium, the GIC calculates[1] member premiums.

Mr. Kane walked the Commissioners through the analysis numbers that lead to the low and high estimates for the status quo (no plan changes, no contractual changes, no changes in member behaviors, etc.). The Executive Director underscored that the potential increases are a range and that the range gets narrower as more information is gathered, building towards pricing. She then asked Mr. Kane to speak about the impact pharmacy might have on rates.

Mr. Kane stated that for pharmacy, his team looks at rebate experience, looking back at other years. From there, savings are recast, based on where FY18 ended up. There is a lag of about 8 months before these settle, therefore some of this is estimated.

Commissioner McAnneny noted that the range of 3-7 is higher than other years and asked if this is because of unit price or something else. Mr. Kane replied that part of the issue is that the numbers are being talked about earlier than other years. The forecasted trends do represent unit cost, utilization, and case mix. He noted that there hasn't been a huge change in any of these. He stated that the range is really due to some refinements that need to happen when more information is available, particularly around pharmacy.

The Executive Director noted that two years ago the GIC was facing double digit increases and made significant increases in deductibles. Following that, the GIC ran a procurement and wasn't in a position to have done this exercise. She noted that these aggregate numbers don't mean members are looking at 3-7 % increases next year. She noted that a big driver of why the GIC must do these analyses now is because the state is preparing its budget.

Commissioner Bradley asked Mr. Kane to speak about provider contracting and its impact on cost increases. Mr. Kane stated that the medical plans were asked for trends for 2018-19 and 2019-20. Provider contracting represents about 1/3-1/2 total trend changes from the health plans.

---

[1] GIC NOTE: These are technically estimates of member premium, since the state budget is not usually finalized and it is in the state budgeting process where the member contribution ratios are actually determined for Commonwealth employees. Municipal employees may have different contribution ratios, based on those set by each municipality.

Dr. Levin-Scherz mentioned that in response to Commissioner McAnneny's question about unit cost, there has been an overall increase in the market. He stated that while utilization has gone down in some areas, unit cost has outstripped those savings. He then stated that he would change topics and discuss some of the elements of plan design. He stated that it was the GIC's goal to make plans fairly uniform, but if there are differences, they should be intentional. He mentioned that he would review where differences were found that were likely unintentional and which would likely change in the future.

Dr. Levin-Scherz stated that mental health is a priority area for the GIC. The GIC is looking to ensure people have access to this care and is considering lowering copayments in certain mental health areas. Currently, some plans were charging inpatient copays and some weren't. For example, applied behavioral health analysis services was an area where some plans were charging $20 copays for each service and one plan wasn't charging any copays. The GIC staff will likely be recommending that these copays be set at $10 across the board.

The Executive Director stated that in prior listening sessions, she heard that members thought they needed to go to certain plans for certain benefits. She underscored that it is not the GIC's intention to have members shop the plan offerings for certain benefits, such as behavioral health which needs to be a standard, quality benefit across all plans. She underscored that the GIC intends to provide intentional consistency.

Dr. Levin-Scherz stated that last cycle, there were too many other items vying for attention, but benefit uniformity is the next step. He then suggested that urgent care should have consistent office visit copays. Commissioner Kaplan asked about urgent care utilization and whether there had been an uptick.

Dr. Levin-Scherz confirmed that there had been an uptick in use. He explained that it is unclear whether this is an "if you build it, they will come" phenomenon and that ideally the uptick in use would be coupled with a decrease in ED use. He mentioned that some people are using urgent care in place of a primary care physician, which isn't ideal.

Dr. Levin-Scherz then stated that other areas the GIC would be looking at for copay harmonization would be outpatient surgery and ambulatory surgery in general, and high technology ("high tech") imaging for which the best practice is to require prior authorization. He stated that ambulance services was also being looked at for harmonization, but clarified that this is not around emergency services transport. Rather, it focuses on hospitals that lack catwalks and must transport patients from building to building by ambulance. The last area Dr. Levin-Scherz noted was private duty nursing, which is generally not covered. He stated that currently two GIC plans cover these services, that the utilization is low, and that the recommendation will be not to cover the service.

Commissioner Edmonds asked, while the policies make sense, how will these policies impact the retiree segment. In response, Dr. Levin-Scherz stated that private duty nursing may impact the retirees, but reiterated that it's unusual for plans to cover it. Commissioner Edmonds asked again whether or not Dr. Levin-Scherz had information on private duty nursing coverage impacts to retirees, and requested to be provided with the impact and numbers.

Dr. Levin-Scherz then turned the discussion to tiering, showing a slide with a graphic from the Health Policy Commission (HPC). The HPC's analysis identified which providers are most expensive and least expensive, after being risk adjusted. Physician led organizations tend to have the least costs; academic medical centers (AMCs) are the most expensive. Teaching hospitals and others are somewhere in the middle. Dr. Levin-Scherz noted that this distillation should be something easily understood by most members, and that the GIC is asking its health plans to try to use this framework to tier (providers, specialists, hospitals, etc.).

The Executive Director stated that her goal is to use and leverage state assets more. She said that the GIC had asked the HPC whether the GIC's cost stratifications mirror the market's and the HPC confirmed that it did.

Dr. Levin-Scherz stated that the GIC advised health plans last plan year to do group based tiering, based on cost and quality metrics, but only two of the health plans were able to fully implement this (Tufts and Harvard Pilgrim Health Care). The others were able to move slightly towards that, but some plans needed to stay with the individual specialist based tiering. This coming plan year, the GIC will allow plans who have tiered by group/cost/quality to continue with this method and asked the other plans to implement a 3 tier program based on the HPC standards: Tier 1 would include physician led organizations and groups, tier 3 would include AMCs, and the rest would be in tier 2. He further explained that if a plan demonstrated that they had advantageous contracting or experience with an AMC(s), the plan could seek GIC approval to move the AMC(s) into Tier 2. Dr. Levin-Scherz added that these tiering methodologies would apply to broad network plans. He stated that regional or other plans may have some other considerations that may make application of these models untenable or undesirable. The GIC would work with regional plans to address issues appropriately. He concluded that this approach would give members reasonable choices and create meaningful differences.

Commissioner Sinaiko asked whether this include hospitals. Dr. Levin-Scherz stated that if the physician is based at the AMC, then the physician would be in tier 3. He added that, realistically, where physicians are affiliated with more expensive places, everything is more expensive, not just the hospitalization or office visit. Commissioner Sinaiko asked whether the hospital and other outpatient services were going to have differential copays. Dr. Levin-Scherz said that he would be addressing those topics next: high tech imaging and ambulatory surgery.

Designee Denniston stated that the Attorney General's report informed us that total medical expense (TME) of an organization is one measure, but rolled into that is a big range of services provided that have a range of high verses low costs. Dr. Levin-Scherz acknowledged that Designee Denniston was correct that the most expensive hospitals aren't necessarily the most expensive across the board in absolutely everything, but noted that those hospitals do often have a higher multiplier on fees. He then asked: How do you steer people to the right facility that will deliver good care, high quality, at a lower costs? He stated that the GIC had picked two areas where they felt would make the most difference on this, high tech imaging and ambulatory surgery.

Dr. Levin-Scherz first discussed high tech imaging, noting that it costs more at hospitals and less at outpatient places. He stated that currently, there is a $100 copay for non-emergency MRI (magnetic resonance imaging) and CT (computed tomography) scans regardless of location. The GIC is proposing having differential copays for inpatient verses ambulatory facilities. He reminded the Commission that they had previously discussed the "smart shopper" program (offered by some GIC plans), which is one way to try and steer people, but offered that differential copays of $75 v. $200 might be a simpler way to steer members. Dr. Levin-Scherz noted a research study by Michael Chernew that found even where there are significant low cost shopping

opportunities; people usually went by 6 less expensive places for a more expensive knee MRI. He further noted that MRIs are a commodity product, meaning that there's no notable quality difference based on location.

Commissioner Bradley asked, that while Dr. Levin-Scherz knows there's no difference, does the average consumer? Dr. Levin-Scherz responded that he believed the first hurdle to consumer education is getting their attention. He acknowledged that there may be good reasons for some individuals to have their MRI at a hospital, but the cost of that hospital MRI is still much higher and therefore those individuals ought to pay more out of pocket. Commissioner Davis remarked that most people put tremendous trust in their doctor and it is unlikely they will contravene the doctor's referral unless they are very bold. She noted that it's really about changing the market. She questioned whether hospitals will lower their costs because they are losing patients and asked what percentage of business the hospitals need to lose to impact the market.

The Executive Director stated that she was so captivated by the finding that the physician led practices were so much more cost efficient, that she wanted to product-ize it. She expressed interest in finding a way for members to know in advance what the difference in costs would be based on the provider they choose. She endorsed the idea for members to make as many choices as possible at the time of enrollment, and the costs would flow downstream based on the doctors associated with the plan selection.

Commissioner Kaplan noted that she had heard anecdotally that some of the locations for MRIs, like Shields, don't provide the physicians with the results as quickly as they would if they had used the preferred place. She noted that the member has to get a CD or make the effort to ensure that the results are transmitted to the doctor. She asked Dr. Levin-Scherz to address these anecdotes.

Dr. Levin-Scherz stated that there is a known issue with providers finding outside test results in certain electronic medical records (EMRs), because outside MRI reports - even when they are scanned in - may be filed in a miscellaneous category in the record. He emphasized the cost can vary from $300 to $1100. He stated that other employers use coinsurance, not co-payments, and that would be another way to address the cost issues. He noted another means of addressing it would be reference pricing, for example, $400 would be covered, but anything over that would be the patient's responsibility.

Commissioner Sinaiko stated that there is a lot of switching in the market to these lower cost providers. She noted that the proposal is more like an in-network/out-of-network issue and is simpler than co-insurance. She emphasized that member communication will be necessary and if the GIC implements a prior authorization for imaging, it would be a good point to try to outreach to the provider/patient. Commissioner Sinaiko also noted that the doctor relationship point is really important; people driving by six places, as the study demonstrated, is because they went to the place their provider sent them. She stated that providers really need education, too.

Dr. Levin-Scherz noted that there was an additional hurdle when the referring providers are employed by the higher cost places, too.

Dr. Levin-Scherz next talked about proposed changes to ambulatory surgery. He stated that currently, all GIC plans have a $250 copayment. He proposed a differential copayment where accessing this service at a hospital would remain at the $250 copay, but if it were accessed at a non-hospital location, it would be $150. He noted

that this change may eventually have an impact on provider contracting. Further, he stated that the cost savings for the GIC would be modest, because the savings would be offset by the lower copay amount.

Designee Veno agreed that the two areas (high tech imaging and ambulatory surgery) are ripe for differential copays because there is high variation in price depending on location, but consistent quality regardless of location. He agreed that member education will be essential, especially around the fact that there's no difference in quality and only in price.

Commissioner Davis agreed that with this approach. She stated that the market drives a lot of the decisions – U.S. News and World Report ranks doctors – and people read those rankings. Right now, people don't think about copays, especially for specialty care. She noted that when people make a plan selection, they probably aren't in the position to understand or consider the individual medical choices that will come up throughout the year. She stated that the AMCs do well because of the perception that they are highest quality in care and they have the best physicians; therefore, the GIC needs to tackle that optics issue when members actually go to choose their care.

Commissioner Edmonds echoed what Commissioner Davis stated. She underscored that it might be especially challenging to steer members who have had complications and for those who need regular exams. She stated that these people may not find the trust to move to a different facility after being in the care of an AMC.

Dr. Levin-Scherz reminded Commissioners that, especially on the ambulatory surgery side, not everyone will move, but the differential copay creates a lower friction means of driving location choice.

Commissioner Choate agreed that the right services were selected because they have been commoditized and providers are starting to advertise these services, too.

The Chairwoman stated that the discussion needed to end.

Commissioner Davis voiced concern that she wouldn't want the GIC to get to a point where if a member couldn't afford as much, they have to go to a lesser quality institution, even if it's the perception that it's a lesser quality institution. She stated that she does not want GIC members to feel that they're at a second rate place because they can't afford it. Dr. Levin-Scherz stated that one of the goals is to continue access to excellent coverage available for everyone.

## IV. Employee Assistance Program (EAP) /Optum (INFORM)

The Chief of Staff introduced Linnea Walsh to update the Commission on the EAP program.

Ms. Walsh stated that Optum has been communicating to our members that the EAP is available. She stated that Adam, the GIC's member integration specialist, would provide an update and outline the next steps for the program.

Adam Mintz stated that the EAP *Mass4You* program kicked off in July, 2018. He said that it had been focused primarily on communication to members, as it was brand new for many employees and employees may have been unfamiliar with an EAP. He said that print media, electronic communication, and "boots on the ground"

were the different means of communication. He noted that he is specifically trying to build relationships with different agencies and is targeting ones with the potential for high needs, like DCF (Department of Children and Families). He indicated that as the program continues to operate, utilization and other data will be provided to the GIC and presented to the Commission.

## V. Willis Towers Watson (WTW) Amendments (VOTE)

The General Counsel presented two amendments to the GIC's contract with Willis Towers Watson (WTW). The first amendment was for a digitized annual report and the second was for data analytic support. Both are maximum obligation contracts.

The analytic support amendment will fill a gap while the GIC looks to hire an analytic expert. He said the contract will run through the end of the fiscal year with a maximum cost of $64,080.00; however, the GIC only will pay for services rendered.

The annual report amendment will enable the agency to complete a required annual report. He noted that the GIC was looking to move the report to a digital platform. This amendment had a maximum value of $59,700.00. That amount included an allocation of $10,000.00 for optional services.

The Chief of Staff noted that the annual report will be like a corporate annual report and she believes this would be a good test case for the GIC to attempt to digitize the report.
Designee Denniston asked whether this was an anticipated annual cost. The Chief of Staff responded that it would be an annual cost.

Commissioner Davis motioned for a vote to approve both amendments. Commissioner McAnneny seconded the motion and both amendments were unanimously approved.

## VI. Closing: Out & About, Misc. Updates, Wrap-Up & Discussion & Other Business

The Chairwoman thanked Commissioner Margaret Sullivan for her service, recognizing her retirement. Commissioner Thompson thanked the Commission, the Executive Director, and her staff for their responsiveness to the requests of the Commissioners regarding presentations. Commissioner Thompson said she was happy that there is a raised awareness in the member experience and she is confident that her replacement will do an amazing job.

Commissioner Choate moved to adjourn. Commissioner Clinard seconded the motion. All Commissioners voted to adjourn. The meeting ended at 10:33am.

Respectfully submitted,

Roberta Herman

Roberta Herman, M.D.,
Executive Director

# Appendix A

Materials Distributed at the December 6, 2018 Commission Meeting

1. December 6, 2018 Meeting Minutes
2. Commission Meeting Package-October 6, 2018