GIC COMMISSION MEETING
Thursday, June 6, 2019
8:30 A.M. – 10:30 A.M.

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

MINUTES OF THE MEETING

NUMBER: Six Hundred Forty-five
DATE: June 6, 2019
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)
MICHAEL HEFFERNAN (Secretary of A&F) Designee Bill McNamara
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)
ANNA SINAIKO, Ph.D. (Health Economist)
TIMOTHY D. SULLIVAN (Massachusetts Teachers Association)
KEVIN DRAKE (Council 93, AFSCME, AFL-CIO)
ELIZABETH CHABOT, (NAGE)
MELISSA MURPHY-RODRIGUES (Massachusetts Municipal Association)

Absent:

EILEEN P. MCANNENY (Public Member)

I. Approval of May 2, 2019 Meeting Minutes

The Chair called the meeting to order at 8:32 am. After opening remarks, she requested a vote a on the minutes. Commissioner Kaplan moved to approve the minutes seconded by Commissioner Edmonds. The motion passed unanimously with Designee McNamara abstaining.

II. Director's Report

The Executive Director noted that they had a lot of material to cover in the meeting and breaks would be provided.

- Annual Report release

The Executive Director reviewed fiscal year end activity and noted they were in the process of implementing the FSA contract. She indicated that the GIC would be shortly releasing its first digitized annual report covering FY 2017-2018, it is in its final stages of editing and it should be released later this month.

- Legislative Update

The Senate passed their version of the FY2020 Budget on May 23rd. The GIC line items have been fully funded for levels that were proposed by the Governor. The House and Senate were engaged in a conference committee to finalize the budget. The Executive Director was pleased to report that GIC balance billing protection had been included in all versions of the budget. Commissioner Davis inquired about the budget and how it was set. She wanted to know if the Governor proposed a dollar amount or did the GIC propose the number? The Executive Director explained that the GIC made the request for a proposed amount and thankfully they received what they requested.

- Stakeholder Engagement

For a little more than a decade, cities and town have had the opportunity to enroll in the GIC for their health insurance. Throughout the summer the Chief Financial Officer, Jim Rust, and the Director of Legislative Affairs, Mike Berry, will be doing municipal site visits to see how the GIC is doing, focusing particularly on Lexington, Brookline, Somerville, Weymouth and Lowell.

On a follow up to the previously discussed AFL-CIO exchange with Steve Tolman, the GIC was in the planning stages of setting up a meeting to discuss ways they can work constructively together and move forward. The meeting most likely would not happen until the end of July.

- Staff Updates

The Executive Director then moved on to staff updates and noted that Brock Veidenheimer, Senior Human Resources Business Partner, started with the GIC on May 28, 2019 and Margaret Anshutz, Senior Health Data Analyst, started on May 6, 2019. Margaret came to the GIC with much experience from CHIA (Center for Health Information Analysis) where she was the manager of special projects and was instrumental in helping implement its health system performance and consumer quality website. The Executive Director was very happy and felt lucky to have Margaret join the GIC team. She informed everyone that Catherine Moore, Budget Director has been on leave and was back. Catherine was working with, Jim Rust in Fiscal Affairs. She anticipated sending out a new announcement soon on the decision on the Benefit and Vendor Management Director. Decisions regarding a new Chief of Staff are deferred for the moment.

The Executive Director shared that she had received a call from Lisa Guertin, President of the Northeast Region of Anthem Blue Cross/Blue Shield informing her that UniCare had reached a tentative agreement to acquire Beacon.

[10:02 am Commissioner Melissa Murphy-Rodrigues entered the room.]

The Chair asked everyone, to pause for a moment and welcome one of the new Commissioners, Melissa Murphy-Rodrigues, Melissa represents the MMA and works for the town of Sudbury.

The Executive Director then turned the floor over to Dr. Jeff Levin-Scherz with Willis Towers Watson.

III. Medical Trend Management & Out of Pocket Report

Dr. Levin-Scherz stated he would be presenting a report on is what has been going on with out of pocket expense for the GIC. He wanted try to put it into context of overall healthcare cost. Out of pocket costs are deeply related to the overall healthcare cost. Everything the health plans do to control health care cost, in general, makes it easier to not increase out of pocket cost.

Dr. Levin-Scherz presented slides showing that every year premiums in the US have increased faster than wages and non-health care inflation. This problem is thus not unique to Massachusetts or to the GIC. The major question we ask is "What is causing the increase in premiums?" Is it because the GIC members used more services, or because members are getting older or they are getting sicker? When it's analyzed, it's mostly because prices are going up due to increases in unit price, not increases in illness or utilization.

Data from United Health Care, Aetna, Cigna and Kaiser, was presented. It showed that members were using 5% fewer services, but these services cost 10.5% more than years ago. Unit prices were the driving force for increased commercial care in the U.S. representing more than 10% of the total cost of health care.

Commissioner Davis asked what was actually happening to make the cost rise? Dr. Levin-Scherz explained many other countries don't have the rate of increase that we do. He noted that people today are taking more expensive drugs than they used to; this is not 100% bad, some of these drugs can now cure Hepatitis C, control HIV and many chronic illnesses. However, the level of the increase of cost in the United States is much higher than everywhere else suggesting that something can be done about it.

Commissioner Sinaiko noted that while there is some evidence of price growth over time, like the cost of labor, it does not explain the increases. Much of it is connected to increases in market power in the healthcare industry. Providers have more negotiating leverage so the question is whether there is an opportunity to move away from paying those higher prices without losing a lot of value.

Dr. Levin-Scherz explained the increases in administrative costs are very high but the increase in wages and benefits for nurses and doctors, were not very high. They did a large employer survey and found that the cost of premiums went up less than the costs of care. Employers did this through "health care buy down." Employers are moving towards plans with fewer benefits, and while there is some improvement in their utilization management, most of the employer savings was the result of cost shifting. People are spending more on health care across the country. This has been going on for 13 years and it is terrible. There are manufacturing workers making $15,000 a year with $6000.00 family deductibles. Cost shifting is a straight forward, immediate way to lower health care costs for healthcare sponsors. Unfortunately, other things you can do require an investment over time and it takes a while to see the results. Cutting the benefit level by increasing cost share, means you know you have cost savings for that year.

The same is true for the GIC. If there comes a year with high health care cost trends, the only thing left to do is increase out of pocket expenses for employees. High deductible health plans have exploded over the last ten years. Looking at individual deductibles of $1000 or more, the prevalence of these plans has gone from 17% to 48% over a decade; half of all Americans that have employer sponsored health insurance have individual deductibles that are more than 2-3 times higher than GIC's deductibles.

"Out of pocket (OOP) costs" refers to all the amounts people pay when they access health care services, as distinct from what they pay, typically through payroll, in premium. Dr. Levin-Scherz explained that in a conventional fully insured insurance plan, the total premium is kept by the insurer with more or less profit at the end of the year. However, the GIC is self-insured and pays the carrier a service fee. Our premiums are determined by looking at data for the previous year, national trends, and predicting what the cost will be next year. Based on those factors, the GIC determines the premium equivalent and, therefore, what the members will pay out for premiums.

For the out of pocket report, Willis used GIC methodology that was created years ago and information from the data warehouse. The Executive summary for the report indicated increased out of pocket

spending for FY17 and more so in FY18. Some of the increase in out of pocket cost was just due to medical inflation; however there have also been significant benefit design changes. That said, with the current GIC benefit design, one would expect to see few members with very high out of pocket cost which typically results from coinsurance (GIC has few benefits that have coinsurance). Coinsurance can lead to a really expensive out of pocket costs as when something is 20% of a medical expense which can be significant. For GIC members that experience high out of pocket cost, it is often due to them using out of plan providers or very expensive drugs that have good less expensive alternatives. It is important to note that behavioral health is a special issue, where there are market-wide access issues and providers who simply do not accept health insurance. Overall GIC members spend substantially less out of pocket than either the all employees group or the government and public sector employee group in the survey.

There were a number of questions about how many members were experience high out of pocket costs and why? Dr. Levin-Scherz advised because the networks are robust so in general members should be able to get care in network. In some cases, members who chose limited network plans that typically exclude the most expensive hospitals, go to an excluded hospital for non-emergency treatment. Our quantification is inherently limited because sometimes when members goes to out of network facilities it will appear that they had significant out of pocket costs but providers accept the payment as is and write off the rest, resulting in an overestimate of OOP costs. This is also true of pharmaceutical companies (sometimes, there are incredibly expensive drugs where the specialty pharma company will write off out of pocket and accept payment as is). Alternatively, if members access out of network services, pay out of pocket but don't file a claim, we have no evidence of expenditure, resulting in an underestimate of OOP costs. The Executive Director stated when they did a drill down and excluded on out of network utilization there were only 2 households that had very high out of pocket costs. Nonetheless, out of network utilization accounts for a significant portion of high spending, suggesting that we have work to do educating our members on utilizing their benefits.

Dr. Levin-Scherz presented graphs showing that while there are some members who had expenses greater than $10,000, they were very few in number. He also noted that the data was inclusive of all plans including Medicare where, under CMS rules, cost sharing is much lower than in commercial plans. He further noted that the data was very similar for FY16 and FY17 with some increase in FY18.

The GIC faced a big challenge for FY18 as projected premium increases initially came in at more than 10%. Eventually, this was decreased to the 3% percentile range, which was felt to be more reasonable, but also necessitated some cost shifting to get there. Dr. Levin-Scherz noted that as a result of the procurement, there were not any increases in cost sharing last year. Benchmarking of Out of Pocket expenses for commercial plans only, showed that out of pocket costs represented 16% of the total cost of care for the overall database, 11% for the government/public sector database and 8% for the GIC.

Commissioner Anderson noted that it will be difficult to avoid the experience of FY18 if the Commission doesn't pursue strategies to hold down the cost of care.

The Executive Director agreed there are only a finite number of tools or levers available: what WTW refers to as (i) Participation (eligibility/who you cover) (ii) Subsidization (what coverage/benefits are offered and the contribution formula) and (iii) Efficiency (how good a job we are able to do controlling costs/managing for value).

There was brief discussion about the GIC buyout program, its design and low participation.

IV. Strategy Update

- Highlights of the GIC strategic plan

The Executive Director explained the GIC has been working with Accenture since last summer and wanted to give some highlights of the work so far. The two major items were strategy pieces; codification of the GIC overall strategy and business redesign. Some of these items will be implemented as soon as this summer and others will be worked in throughout the year.

The Executive Director then introduced Tom Conroy, who would give a brief overview of the strategy process.

Mr. Conroy explained that when Accenture came in to assist the GIC, they looked at what were the needs of the GIC on a month to month basis. They discovered there were several factors that affected the GIC and created a need to rethink how it operates. Some areas that need to be looked at were demographics, the demographics of the GIC changes constantly as State and Municipal workers fluctuate in age, retire and are hired. The rising cost of health care can be a challenge to the GIC to keep member payments down as well as the state costs.

Another factor the GIC needed to consider was digitization. Society is currently digitalized in every aspect of our lives; while the GIC is not digital at all. It is nowhere near where it should be in terms of technology. The GIC is not up to date with cell phones, laptops or the majority of digital devices they should be connected to. The lack of the digital force is weighing heavily on how the GIC operates.

The last area the GIC should look into is health care plan design. Today's healthcare plans are complex in terms of co-pays, coinsurance, deductible and premiums. It is hard for members to understand. All of these are areas the GIC needs to rethink in terms of how they are operating.

Last fall Accenture brought into focus (3) topics to help manage these forces. The first is what should the GIC strategy be, what initiatives would better help the GIC achieve its purpose and goals. Second, how can the GIC better use data and analytics to move the market place and third, what does that mean in terms of the core process that the GIC operates with on a daily basis to help members and to increase participation.

The GIC started by listening to members and stakeholders. In 2017 it began a series of listening sessions that were held on a regular basis. The sessions were based on what was happening with the

GIC, what are their needs, engagement and ideas, thoughts and strategies. They found better communication is needed between the GIC, the labor community and the Commission. Members wanted be better access to tools and more online availability such as self-service capabilities, transaction history and member transactions.

Commissioners offered suggestions of digital features they thought would be helpful such as the ability to "chat" and the need for more educational awareness and engagement for members.

Accenture found there were several different ways the GIC could achieve savings; mainly by offering a broader portfolio. He was aware that the GIC is a unique place with over 450,000 members with a 7.5% market share providing market moving capacity. Mr. Conroy advised that the GIC use its size to the best of its ability to drive cost down. Improvement, modernization and change should be a major conversation the GIC and the Commission continues.

Mr. Conroy explained the methodology they used that ultimately determined the (6) initiatives they settled on to modernization of the GIC business process, transform the Member experience and manage for value.

The Executive Director highlighted some of these topics particularly the interlocking of strategies. The GIC has been offering the "best" products and programs but with outdated infrastructure. It wanted to get infrastructure improvements started as quickly as possible. They were able to use leftover capital funds for work that will start in July and follow through into December. The GIC hopes to start building a really contemporary environment. It was looking to move ultimately into an active enrollment process and to be able to give members a good experience in customer service, as well as broadening their portfolio, transfer performance risk and a variety of other topics for discussion.

There was a question about what was meant by making the process more active. The Executive Director explained that you go through the enrollment process, it's not very user friendly, you enroll in a plan when you join state service and usually members do not make any changes until they retire. An active process would engage the members both at annual enrollment and throughout the year. An active enrollment is a better active relationship with the members; and provides an anchor for the relationship with the GIC. The Chair gave an example of when the GIC offered the EAP plan, they had no way to communicate to every member.

The Executive Director explained it is a long term goal to get the GIC up to the modernized standard they want it to be, however there are steps they can take right now that would help both staff and members. The GIC was just completing an upgraded eligibility and enrollment platform, MAGIC, when she started.

The Executive Director introduced Anusha Raturi who presented a brief picture of what the GIC enrollment process looks like today and where they would like to see it move towards. Anusha pointed out some of the short term changes that were in the works to modernize the GIC. It was implementing

a CRM tool (Customer Relationship Management) with (3) key elements that will address operational efficiencies including, a case management system (sales force), updating of imaging and e-forms. With these systems in place, the GIC would be able to track a customer's experience from end to end. The case management system will allow the GIC to track every contact with a member shared across the agency and documented in real time. Upfront document imaging will provide faster, more efficient and more accurate data processing. Docu-sign and e-forms will allow coordinators to work with forms online, rather than having to process them manually and deal with paper forms.

There was extensive discussion regarding how these improvements could impact everything from member enrollment to waiting periods for coverage. The Director of Operations explained some of the existing constraints that constrained some processes even with modernization such as the 235 payroll systems the GIC interacts with. He noted that the GIC hoped to implement educational tools for members to use that would help them track their benefits, see their elections and track and plan their changes. The Executive Director stated that from July through December; the GIC would be implementing Sales Force, Docu-sign (a form that you fill in electronically) and E-form imaging. She explained that short-term changes are changes the GIC can start implementing now throughout the end of the calendar year and rolled out for FY2020enrollment.

[10:00 am The Chair then advised the Commission they would take a 5 minute break.]

[The Commission meeting resumed from Break at 10:08 am.]

V. Operations & Open Enrollment Overview Results Finance 101

- Member Engagement
- Phone Metrics
- Benefit Fair Results & Report Out
- Membership Transfers & Analytics

The Executive Director continued the meeting with an Operations and Enrollment update from Nick Vogler, Digital Engagement Technician and Paul Murphy, Director of Operations.

Nick Vogler provided an overview of member engagement for open enrollment, including paper based and digital based products. The benefit decision guides and the benefit statements both of which are moving towards a completely non-paper product. These highlight the current benefits members have and the options to enroll in. The GIC obtained over 6,500 email addresses from their websites during open-enrollment. The website featured a launch-over page, rate sheets, special enrollment sheets, and a bright yellow banner ad that created a link to the "Turning 65 video." The GIC received a lot of positive feedback on the video and the video was ranked as one of the "Top 5 videos" on Mass.Gov. They also used the hashtag #knowyourbenefits2020 on Twitter to explain common healthcare terms and engaged on social media.

Internally, staff had training sessions on the upcoming changes and highlights for the upcoming benefit year and they actively analyzed call volume and reassigned staff based on operational needs to handle high call volumes. Overall for open enrollment, the GIC staff supported over 48,000 members. The GIC website was the most popular form of member engagement for members with over 30,000 visitors utilizing the website during open enrollment. Phone calls were the next most popular form of communication with the GIC receiving over 15,000 member phone calls. This provided great insight into the open enrollment period. The GIC website gained more visits than any other open enrollment method, more so than actual phone calls. Phone calls went down compared to last year's numbers of 41,000 at open enrollment.

The Director of Operations briefly discussed efforts to enhance the email capture process. He then discussed the transition to the new FSA vendor (Benefit Strategies) effective for July 1. Open enrollment for the FSA plan was totally 100% electronic, members had to enroll online with no paper. The vendor, who also handles the Commonwealth's transportation benefit, enrolled 16,067 members in the program. This allowed for state employees to be able to implement both benefits under one account.

He noted that LTD (Long Term Disability w/Unum) was still in open enrollment, with an extended enrollment deadline of June 14, as they found that people were concentrating on health insurance and really did not have time to focus on the long term disability. The hope was that the extension would allow more members to enroll. The open enrollment numbers will be presented at the September 19th meeting. Currently, the GIC has about 40,900 members in the Long Term Disability program.

In terms of open enrollment, the GIC held 9 benefit fairs. The fairs were well attended and some locations allowed for extended hours. One new entity joined this year, BICO Education Collaborative adding 160 new members to the GIC. The fair in Wrentham extended until 4pm so the BICO educational collaborative teachers could attend. Overall, 32,070 members attended all of the benefit fairs across the state of Massachusetts. A total of 3,850 members changed plans, this figure also taking into consideration, the newly insured members that have never had GIC benefits, such as new state employees.

Four municipalities, Dracut, Hopedale, Winchendon and Barnstable, were leaving the GIC resulting in a loss of almost 1900 members as of June 30th. As of July 1, 2019 there were 425,630 active members enrolled in the GIC health plans.

There were questions as to why municipalities leave the GIC and why members transfer plans. The Director of Operations stated municipalities were most likely offered a better deal than what the GIC could offer and/or different products. Municipalities look at and browse other products and go with other vendors such as Blue Cross/Blue Shield who can offer them more options. The General Counsel added that the GIC is the insurer of last resort because it does not take risk into account; municipalities that are considered a bad risk will often have more favorable rates from the GIC for comparable

products. As time goes on, their risk will improve and at that time, they realize they may get a better deal from other carriers by going to a new vendor.

The Director of Operations addressed why members change plans. He noted the reasons vary. Some people, as they retire, do not want to be restricted; they want a broader, flexible plan with more options. Some members look for a broader network plan with more flexibility, rather than paying for a limited network that does not work for them. Others may not like referrals and transfer out of a limited network plan that requires referrals to a plan that does not. People considering retirement, often don't want to be restricted and want a broader network plan even though a limited network may work, it varies.

VI. Governance

- Amend By-laws to add Executive Director removal provision

The Chair then turned the floor over to the General Counsel to discuss the Governance minutes and the updated amendment to the bylaws. The General Counsel reminded the Commissioners that at the last meeting, the Commissioners voted on the bylaws and it was noted that there were procedures to appoint the Executive Director, but no mention of removal procedures. An amendment was requested to address this. The General Counsel noted he went back and looked at the connector and health policy commission bylaws to review their policies and neither of them incorporated any language regarding removing the Executive Director. He then went back to the statutes to see if there was any language addressing removal of the Executive Director; usually there is a higher standard for removal than for appointment. The GIC statute only states the Commission may hire an Executive Director. It is the Commission's choice as to who the person is and he/she serves at the pleasure of the Commission. Given the dearth of applicable provisions, he made the language parallel to the resignation of the Chair. The Bylaws now state "The Executive Director serves at the pleasure of the Commission and may resign by sending a written letter of resignation to the Commission and the Chair. The Executive Director shall otherwise serve until removed by a 2/3 majority vote of the Commission members with or without cause." He hoped this addressed the issue and resolved any concerns.

The Chair asked for a motion to approve the removal language of the Executive Director into the bylaws. The motion to approve the language was made by Commissioner Choate, seconded by Commissioner Edmonds. A roll call vote proceeded: The Chair voted in the affirmative, along with Commissioners Kaplan, Anderson, Bradley, Choate, Chapdelaine, Chabot, Clinard, Davis, Edmonds, Gentile, Designee McNamara, Murphy-Rodrigues, Sinaiko, Sullivan. The motion carried 17-0. The Chair thanked the Governance committee and the General Counsel for their hard work.

VII. CFO Update

- Authorize Trust funds expenditures for IT, Communications & Temp Help
- Budget Update –Fiscal Year 19 –State Share of Claims Expenditures

- Fiscal Year 18 Audit Report reviews of Fallon, UniCare, Beacon and Health New England

The Chair then turned the floor over to Jim Rust, The Chief Financial Officer

The CFO stated he had (3) items of business he would be discussing. The first item regarded the trust fund spending request and required a vote for authorization to use the funds from the trust fund for IT, administrative services and communications budgets, in the event that those area's needs exceeded applicable A&F appropriations. This was a safety net. In the last 2 years, the GIC did not exceed the use of the appropriated funds even though the Commission had approved similar use of the trust fund. He explained that these funds may be used for the potential increase in digital presentations, to supplement electronic forms, increasing digital communications material and more use of multi-media outlets for educational purposes. He presented total fund request for the year of $467,000 broken down by line item. He noted there was currently 2.8 million in the trust. The CFO requested the Commission approve use of those funds as described.

There was some discussion about whether the individual line items added up correctly and the CFO explained that each dollar amount is used for a specific department and is an estimate, not the full dollar amount and rounds up to about $467,000.

There was discussion regarding the use and availability of capital funds. The CFO advised that capital funds are allocated on an annual basis and the GIC received $500,750 in this fiscal year and there will be another request in FY20.

The Executive Director explained that last year the Commission approved use of the trust fund; however the GIC did not need to use it. She felt that they didn't yet know what they might need; this may be a busy year. It would make them feel more comfortable to know the funds were there to use as they see fit and that the Commission supported the mission. This would allow the GIC to continue on with the program and not have to halt it because funding had run out.

Commissioner Kaplan asked a number of questions about the use of temporary employees. The CFO explained that temporary employees are capped at 22 in the proposal to allow the work force to flex as needed where positions will not be long term. The CFO noted he could provide an update regarding the current filled temporary positions at the next Commission meeting.

There were questions regarding the number of laptops that were needed and the amount of funding that would cost. John Harney, Chief Informational officer explained in the past, funds for computers have come from A&F and the appropriation. In previous years, they did not have enough to cover the full budget of computers or laptops. The GIC anticipates that as it modernizes it will need to invest in more computer hardware and this funding request is basically as a safety net in case additional funds were needed in the future.

The CFO asked for a motion to approve the use of the trust funds in the event appropriated funds were insufficient to meet the GIC needs. Commissioner Clinard moved to approve the trust fund request, seconded by Designee McNamara. The motion passed unanimously.

The CFO provided a brief budget update through April 2019. The GIC surplus through April was $8.3 million dollars in the appropriation budget for claims. On a 1/12 budget basis this could project to approximately $28M at year end, although season adjustments could result in a larger surplus. In any case we expect to be close to the $1,736,038,348 annual claims budget. The CFO noted that the dental and vision budget has a small deficit of $3,158. This deficit is projected to be under $100,000 by year end.

The CFO then turned to the results of the plan audits for FY18 which covered July 1, 2017 through June 30, 2018. Audits were conducted of UniCare, Health New England, Fallon Community Health Plan and Beacon Health.

The CFO then introduced John Meca with IBM Watson Health who presented a brief summary of the audit results and review of the audit coverage and scope.

John Meca explained that the GIC had $4.5 million dollars in claims for FY18 and paid out $885 million dollars in claim payments. Audit components consisted of claims processing, access and operational reviews. A primary piece of the audit is the audit of the claims process. He explained the difference in their 100% of claims audit methodology from the more common random sample approach and why they believe their approach captures more errors. Overall the audit results were favorable. Administrators had done a good job on behalf of the GIC. They had the proper organizational structure and processes in place to serve the GIC and all had acceptable levels of claims processing accuracy. All administrators had exceptions in the .22 – 1.37% range compared to typical plan performance in the 1-2% range of claims processing accuracy. The biggest areas of exceptions across all carriers were co-payments. These types of errors could affect the members' out of pocket cost. The more significant claim areas with over payments were group and individual therapy, office visits, ER visits and diabetes education. Underpayment groups included ER care - Urgent Care centers, outpatient lab services and the failure to waive copayments for inpatient admissions from an ER facility at a different location. Another area of claims exceptions identified was administrators paying for non-covered services such as supplemental equipment for hearing aids, alternate therapy or outpatient lab services. Some larger areas in the category were issues with eligibility; claims were paid after the member was ineligible. Another administrator was found to be paying claims with a gender and diagnosis code conflict because there were no edits in its processing system, another paying for ambulance claims were there was no related medical claim.

A Commissioner asked about the payment of claims with a gender diagnosis conflict. John explained that, if, for example, a claim for a male member was submitted for a procedure or test that is typically performed for a female (e.g. mammogram, hysterectomy) it would result in a "conflict". The Executive

Director explained this was a traditional, standard edit. Inconsistencies with procedure and diagnosis codes will flag cases for review, if the system does not flag them there may be something wrong or perhaps there is no edit in the system.

The overall Operational Review showed administrators were performing well. All administrators except one missed one or more performance guarantees for claims processing and customer service metrics including claims turnaround time, processing accuracy, average speed to answer and call abandonment rate. Two administrators did not follow best practices for Business Continuity planning.

The General Counsel reminded Commissioners that the audits are retrospective, that all plans are now self-insured, unlike during the audited period, and that the GIC had followed up on the audit findings and most of the deficiencies had been remedied and appropriate financial recovery done.

VIII. Contracts & Amendments

- Warehouse Procurement –PreRFR discussion
- Update on Fiscal Year 20 amendments for health & pharmacy plans

The next areas of discussion were Contracts and Amendments; the most important was the Warehouse Amendment that was up for renewal in FY20. As the GIC thinks about analytics, its needs go beyond the claims data. As the GIC approaches the new procurement, it wants to focus on securing a warehouse with a robust capacity for ad hoc analytics and data aggregation capability, excellent visualization tools for both internal and external reporting. If anyone had any questions, they should follow up with the General Counsel, Andrew Stern over the summer.

The GIC is still within the first 3yrs of the large health related contracts and there are no financial changes at this time. The Legal department was trying to have them completed before the end of June. The Long Term Disability (LTD) renewal was contemplated to be effective on July 1st.

IX. In Closing: Out & About, Misc. Updates, Wrap-Up & Discussion & Other Business

- Thank You—Theron Bradley

The Chair stated that Commissioner Theron Bradley had informed the GIC and the Governor's Office that he was resigning from his post. Commissioner Bradley had served with the GIC for 18 years; he had been appointed to the Commission in 2001 by Governor Jane Swift.

The Chair thanked Commissioner Bradley for his dedicated service to the GIC along with his Human Resources expertise that he brought to the Commission. She then presented Commissioner Bradley with a Governor's Citation in recognition of his 18 years of dedicated service to the GIC.

Commissioner Theron expressed it had been an exciting 18 years. He thanked everyone and wished them good luck. The Chair asked for a motion to adjourn. Commissioner Chapdelaine made the

motion, seconded by Commissioner Clinard and approved unanimously. The meeting adjourned at 11:15 am.

Respectfully submitted,

Roberta Herman, MD
Executive Director