GIC COMMISSION MEETING
Thursday, November 1, 2018
8:30 -12:00 PM **extended

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

MINUTES OF THE MEETING

NUMBER: Six Hundred Thirty-Nine
DATE: November 1, 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)

KEVIN DRAKE (Local 93, Labor)

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)

Not Present:

MARGARET THOMPSON (Local 5000, SEIU, NAGE)

Vacant Seats:

MMA

I. Approval of Minutes from 10/4/18

The Chair called the meeting to order at 8:35 a.m. She welcomed everyone and noted that a revised version of the minutes had been circulated the previous night. She asked for a motion to approve the minutes. A motion to approve the minutes was made by Commissioner Edmunds and seconded by Commission Kaplan. The motion passed unanimously.

The Chair turned the meeting over to Executive Director Roberta Herman.

II. Director's Report

The Executive Director noted that the meeting would be long and that a break would occur in the middle. She outlined the agenda for the meeting. It would include presentations by sister agencies, intended to allow Commissioners to learn a little bit about the Health Policy Commission and The Center for Health Information and Analysis. She referenced her goal to properly leverage, partner, and coordinate with other agencies that have capability useful to the GIC. Furthermore, the meeting agenda also includes health care benchmarking work that was cut short last time; some regular reports and the finance update; and a discussion about governance. The governance discussion will occur after the break, a change to the sequencing of the agenda.

The Executive Director next spoke about the Flexible Spending Account vendor procurement. The GIC had received multiple bids for a third-party administrator for the GIC's Flexible Spending Account. The bids were due on October 19, finalists will be selected during the last week of November, and the GIC will be presenting a vendor recommendation to the Commission on January 17.

Next, the Executive Director reported on the Annual Health Plan Stewardship Meetings. These were previously called site visits, but this year the health plans were asked to come to the GIC for their meetings with the GIC. These meetings require considerable preparation by the health plans and are attended by senior management. She noted that successful meetings had already been held with Harvard Pilgrim and Tufts Health Plan. The meetings focus on the last contract year but also include conversation about what's going on in the market, what their needs are, and what we are trying to do. These meetings help the GIC understand how to best work with these plans on marketing, creating programs, and understanding what kind of programmatic activity should be done by the GIC verses the plans. She said that the GIC had also met with MetLife, and that other vendors would be coming in before the end of the calendar year.

The Executive Director then spoke about the Rate Renewal for Tufts Health Plan's Medicare Preferred, a Medicare Advantage product. She said that this product will now be on our fiscal year calendar, similar to all other products, but that rates were needed for the transition period Jan. 1 through June 30, 2019. She thanked Tufts Health Plan for being flexible in getting the aligned product in place. She announced that the premiums are going to go down by $10, while noting that this drop was largely due to the Federal Government suspending the tax on insured

plans. Additionally, Tufts will hold the medical rate portion of the premium flat and there are no benefit changes.

Next, the Executive Director presented a heat map showing a Global Look at GIC Mass. Enrollees. She said this is an example of how we're trying to get more data driven and leverage the tools that are at our disposal. She thanked the CIO, John Harney, for his help with this new tool. The map shows the current concentration of GIC membership on the basis of current home address. She noted that it is not possible to get data on the basis of where people work. The home address data showed a very high concentration in the Boston area. The map supported the decisions to hold the Public Listening Sessions in Boston, Worcester, and Springfield (only). She noted that, with these locations, we are covering the market and the showed how the sessions fit into the schedule for decision-making about Fiscal Year 20 rate development. She asked for feedback on what other big things should be included in this calendar.

III. Presentations from CHIA & HPC

The Executive Director then introduced Ray Campbell, the Executive Director at CHIA, the Center for Health Information and Analysis. She noted his role as a Commissioner and that he had served first as a consultant and then as the Interim Executive Director between Dolores Mitchell and herself. She said that his presentation would include summary material from the Cost Trend Hearings an information relevant to the GIC.

Mr. Campbell thanked the Executive Director for the opportunity. He said his goals were to provide an overview of CHIA and give a sense of what it does. He shared that most agencies in state government have a well understood function, but CHIA is unique to Massachusetts. He said CHIA has unique data assets, data analysis, and power to collect data that it manipulates to provide insights and create publications about it. He spoke about its annual report, its most well-known report, which measures performance of the Massachusetts health care system. Other important functions of CHIA are furthering transparency through the Compare Care Consumer website, and new and emerging data sharing initiatives with other state agencies.

He highlighted the unique power of CHIA to collect data from both payors and providers and see how the pieces fit together. CHIA also works with Mass Health and the Connector's data. He discussed the all payer claims database, highlighting its power and its limitations. He described the different types of data cuts that can be done within CHIA. He said that CHIA does not know as much about the GIC's membership as the GIC, but that it can assemble phenomenal system-wide views through these databases, or datasets that it assembles. He highlighted a series of reports that CHIA produces that have an impact in helping to set rates for certain health care facilities and providers.

Additionally, CHIA has recently focused on affordability. CHIA administers market surveys that attempt to understand what motivated people to choose a particular insurance product and what motivated employers to offer the types of insurance they offered. The employer survey asks and looks at what is it that employers offer their employees? What's the uptake? Why did they offer the products they offered? How are they addressing costs control strategies? How much did they spend? These surveys give a very complete picture of what the employer community is doing in

terms of employer-sponsored insurance. Additional income surveys look at underinsurance, uninsurance, and medical debt.

He said that CHIA's most important job is to collect lots of different datasets to support policy making. He summarized by noting that CHIA cranks out lots of reports, related to financial, quality, and other topics in the health care arena. He sees its key role as serving other state entities including the Governor, the Attorney General, the Auditor, and the legislature. It also serves the Health Policy Commission, and EOHHS and all of its agencies, particularly MassHealth and DPH. CHIA also works with the Connector Authority, the Division of Insurance, and the Group Insurance Commission. It also works with organizations in the Massachusetts healthcare delivery system, particularly providers and payers, but also researchers.

The Chair opened the floor to questions. A dialogue ensued. Commissioners McAnneny, Choate, Davis, Sinaiko, and Secretary Heffernan asked questions about how CHIA works with providers, plans, and the GIC.

After some discussion, Mr. Campbell presented key findings from the Annual Report detailing the overall health care system, including overall spending, prevalence of product type, cost sharing for individuals, service-level views of spending categorized by hospital inpatient, and outpatient.

Next, he described CHIA's Transparency Agenda including *CompareCare*. He noted that there has been a statutory mandate for a number of years to have a consumer transparency website. Massachusetts is one of only 10 or 12 states that have an all payer claims database to look at the payments going back and forth between hospitals, between doctors and health plans, hospitals and health plans, minute clinics and health plans, ambulatory surgical centers and health plans. CHIA has used that information and created a consumer tool that lets people look that up relative costs for a subset of procedures.

CompareCare is not a substitute for plan transparency tools. It cannot show what any individual will pay, because CHIA does not have member specific health plan information to do that. He suggested that consumers refer to their health plans' web sites to know their actual expected out-of-pocket costs, because there's a law that requires health plans to have cost estimators. However, he opined that CHIA is playing an important function in showing total cost in the system. A discussion followed about the value and impact of transparency tools.

Lastly, he suggested there is a real problem around interagency data sharing in government. He thinks CHIA has discovered the solution for this, because it gets data from 70 different health plans as part of the all payer claims database. He described how federal regulation and privacy issues have hampered this and suggested that a solution could be coming and that it is being discussed at the secretariat level.

At 9:40, the Chair turned the floor over to David Seltz, the Executive Director of the Health Policy Commission (HPC).

Mr. Seltz thanked Mr. Campbell and spoke to the ongoing and future partnership he envisions with CHIA and the Group Insurance Commission. He gave some background on the HPC. It was established six years ago in the landmark health care cost containment law, Chapter 224. He said that the Health Policy Commission generally thinks about two big things that it works on: strengthening market functioning and advancing the delivery system and the way that we pay for that delivery system. The HPC does research and reporting, and convenes people together in order to address problem areas. It does partnerships, and investments, including grant programs where it gives money to providers to test new ways of delivering health care. It is also a watchdog on behalf of consumers and employers. Its main role is around analyzing market consolidations. For example, reviewing hospital consolidations and acquisitions and what the impacts of those may be on the market.

He presented some summary slides that described Massachusetts' total health care spending growth rates compared to the average United States growth rates for commercial health insurance. He showcased some big challenges and opportunities to further reduce spending left in our health care system including hospital readmissions rates. Another is the amount of low acuity care, just general non-complex care, which can be appropriately and safely treated at a community hospital that is still going to AMC and Teaching hospitals. The Executive Director asked if this data could be presented using just GIC members and wondered if maybe we would see a different trend. Mr. Seltz said yes. Mr. Campbell said that CHIA also has some reports that could be helpful to assess individual hospital performance.

Mr. Seltz then presented some summary findings related to variations in performance among provider systems that indicated that the type of provider organization that provided primary care was hugely important. Physician-led organizations delivered the most affordable care.

The Executive Director complemented the HPC on the data and the construct it had set up. It made intuitive sense and she could see how it could be applied to tiering and product design. She said she would welcome an opportunity to leverage a construct about physician-led versus AMC-anchored. She expressed that this could be an easier conversation for people to understand than the current tiering system that is not intuitive and not really understandable. This led to a discussion about the impact and effectiveness of tiered products. Mr. Seltz concluded that for the hospital-anchored systems, patients are much more likely to use hospital outpatient department services versus physician services, which comes at a greater cost.

Mr. Seltz asked David Aeurbach, Director of Research at the HPC, to present GIC-specific results. Mr. Auerbach described the dataset, which included Harvard Pilgrim, and Tufts Health Plan GIC members, compared to non-GIC members in Blue Cross, Harvard Pilgrim and Tufts. He reported that GIC members have a higher risk score. They tend to be a little bit sicker or more complex than the general-- than the non-GIC population, and they also tend to be a little bit older. He made adjustments for that get to apples to apples.

He presented some overall utilization rates for GIC versus everybody else. Highlights included: GIC members have similar avoidable inpatient utilization, low acuity hospitalization for things that could have been avoided. GIC members have 6% lower Emergency Department (ED) Utilization, and fewer avoidable ED visits. He shared data on spending by inpatient, outpatient,

and professional, findings that showed that the provider group a member choses has a very big impact on spending. This held true regardless of health status. In other words, both healthy members and members with high chronic illness burden are more costly if they're in an AMC-anchored group; this is true across the board by service-- ED visits, hospital stays, preventative visits, office visits, outpatient, lab tests and pharmacy. He said that overall cost in the AMC-led groups is 12% higher than in the physician-led group; the cost differential is largely related to price differentials (not utilization). He said that this research also compared quality measures and quality scores and the quality is equal to or better in the MD-led groups.

Several commissioners and the Executive Director commented on how valuable this data analysis could be, and wanted to disseminate it. The Executive Director said that product design could be more linked to the type of provider system the member accesses. She stated that part of the challenge is to move the focus past, not just what quality of carrier someone has, but how they access the provider system. She is thinking about how the GIC can work with the health plans to influence the choices that people make, and to design our products to reward people who make choices that we know, downstream, will benefit them and us.

Commissioners were asked whether they could disseminate this type of information to their constituents to let them know what is happening in the marketplace. They expressed interest. The Executive Director suggested the GIC is focused on communication for education, and member engagement opportunities. After further discussion, it was agreed to return to this subject in the future.

At 10:22 a.m., Chair Valerie Sullivan called for a break.

At 10:45, the meeting reconvened with Chair Sullivan introducing the governance discussion. She remarked on the previous 6 months of work and the motion, which was approved, to form a governance subcommittee. She announced that several Commissioners expressed interest in participating and that the subcommittee would be comprised of Commissioners Sullivan, Kaplan, Chapdelaine, and Davis. In order to have an odd number of commissioners, the Chair will be the fifth member.

She shared her vision of the need to put together some by-laws that would provide guardrails and that her first task is to arrange a committee meeting in December. Commissioner McAnneny questioned the use of the term governance. She suggested the process was working well and that there should be a committee that's put together for a short period of time. It should not be something that meets on a regular basis. She questioned the need, given current laws and procedures such as Robert's Rules of Order.

The General Counsel responded that in the past there were detailed regulations that set out many of the things you would find in bylaws, but none of that exists anymore. He said he thinks the idea here was to revisit some of that so that future commissioners wouldn't have to reinvent the wheel every time. He agreed that it would be helpful to codify the operating environment in by-laws while making sure that they are consistent with existing regulations. He suggested the larger question is how do we act as a body? When are we acting as individuals and when are we acting as a commission? And how to address nuances-- what is the responsibility of each of us in terms

of communication? Is that part of our responsibility to do that? He suggested that the whole purpose of governance is to give a framework or a roadmap for how we do what we do. He suggested it could be very simple but that it needs clarity and codification so that any new person that joins the commission and reads whatever this group produces in terms of governance, will know exactly how you work.

There was further discussion about communication, the sharing of important information, time frames for reviews, and the procurement process and how to provide input into it. It was agreed that the Governance Committee would meet and then present back to the broader commission in March. Furthermore, it was agreed that the by-laws would be encompassed in one document and would include rules of order, chair elections, communications.

At 11:05, Chair Sullivan introduced Jim Rust, Chief Fiscal Officer

The CFO shared financial reports relevant to the first 3 months of fiscal year 2019. He stated that it is very early in the budget year, so it's difficult to project and draw conclusions from trends, but shared a snapshot of the year to date. He said that in the first three months, the GIC has paid more claims than it did in the prior fiscal year. A few factors go into that variance: changing to self-insured on claims that were previously fully insured increasing the overall amount of claims processed and the carve out of the pharmacy part of our benefit programs, which affects things such as when we see the rebates, and some of the pharmacy spend. The pharmacy claims are now getting to us quicker, as opposed to prior years when much of them came in through the health plans. All this contributes to this trend. Also, there was an extra week in this period, which has caused the appearance of an increase at this point in time. Going forward, this data will need to be normalized in order to compare it to the prior year.

Commissioner Choate asked if the normalizing would lead to a reduction in the variance. A request was made to present a more apples to apples comparison in the future.

Mr. Rust showed the state share of the expenses for all the accounts, and how it broke down each month into the state share. He explained that this will build into our comparison to budget through July, August, and September for the state share of all the programs that we run.

Next, he reported that, in terms of spending against budget, we had been running favorable to budget. We had about a $30 million surplus if we were to look at it as a snapshot in time. However, he had not adjusted the numbers for seasonality in terms of when the claims usually come in, so we are likely right on budget. Last year we were in a similar spot. Viewed against a straight line budget, we would have had a similar surplus and against the seasonal budget, we would have been right on. He concluded that it's too soon to see where we're going to end up, but it appears at this time spending was consistent with prior years.

At 11:10, Tobey Choate departed.

At 11:15, The Executive Director introduced Tom Conroy from Accenture.

Mr. Conroy introduced himself and the Accenture project, and thanked the Commissioners for making time to meet with him and his team. He presented some slides that provided an overview of the timeline and some of the work Accenture had undertaken and will be doing. The timeline highlighted important dates from October 1 through the end of this calendar year. Engagement points included Commission meetings, engagement with Commissioners and engagement with the GIC executive committee, which occur on a regular basis in between the daily work.

Mr. Conroy described three workstreams.

The first workstream is strategic planning. It attempts to answer: What is the GIC business model? What should it look like? What is its purpose? What is its mission? What are its goals? This work will result in the crafting of a three to five year strategic plan.

The second workstream is around data analytics. It attempts to answer: What is the current data analytic capacity at the GIC, and at the GIC's partners or vendors? Willis Towers Watson is one of the key contributors to data analytic capability to the GIC. There are other state entities that have health care data analytic capabilities that the GIC wants to look at and understand how they may be able to contribute to the data analytic capabilities and information that the GIC has access to. Accenture will think through what are those options, what are those potential capabilities, where should they reside, what is the actual capacity that should be in-house at the GIC, and answer a bunch of questions around that.

Lastly, Accenture will look at the GIC's internal operations, the team of about 50 people that work at the GIC day after day. The operations are not modern and recommendations will be made to look at ways to help the GIC upgrade the performance, capability, and modernize that internal operation so that it enables data analytics, strategies, and provides members more value for the benefit options that the GIC is purchasing on their behalf.

Mr. Conroy discussed the work that has been done so far, including the drafting of a purpose statement, the identification of goals and priorities, and the alignment of the strategy work into the other two work streams. The analytics workstream has produced a current state map, and a framework for what kind of data analytics will be most valuable to the GIC. The operational workstream has looked at the current business processes in terms of current state and future state. They will make some recommendations around improving these processes.

Commissioner Davis and Mr. Conroy engaged in a discussion about the intended function of the GIC related to human resources, operations, and member service.

Mr. Conroy shared a finding that the GIC is an outmoded organization. There is room for streamlining and improvement. He commented that a redesign will need to involve a lot of different stakeholders.

Next, Accenture consultant Greg Sexton added further insights into the GIC's business operations and organization and the use of many manual processes and paper forms. The Director of Operations, Paul Murphy, added that these forms and processes are centered on compliance and functionality, such as active employees versus retirees. Mr. Sexton said that one

challenge at the GIC is that currently individual employees do both compliance and customer service. Typically, the more effective and efficient way to set up an organization is to have some people who are focused on customer service and others on compliance. These roles require different skill and mindsets. There may be a way to organize all of the GIC in a way that aligns with those two types of functions.

The impact of Mr. Sexton's observations was discussed.

The Chair summarized that there is opportunity to do two things: improve the experience internally by reducing the demand on staff by streamlining the process and, at the same time, improving member experience, because they're clearer on where to go.

Commissioner Edmonds requested that the GIC provide her with demographic data on GIC employees working in operations.

The Chair said that a three to five year roadmap will be the result of this work and that she would anticipate a combination of optimizing processes and improving capabilities to be in place at the end.

Commissioner Davis requested a 3-5 year roadmap and that the commission needs to understand how Accenture is thinking about, not only the plan, but its implementation. She wants there to be milestone metrics brought to the commission based on the implementation and its progress. She wants the communication to be not just about the minutiae of operations, but the strategy it will change, so that those that represent constituents can then relate to them in terms of how things have progressed.

The Chair said the process is still in the assessment phase.

Mr. Conroy added that the GIC will need the data to create the key performance indicators and show the Commission how it's achieving the goals of health and wellness, customer satisfaction, and financial sustainability. So all three workstreams will fit together very nicely

The Executive Director asked if there were any further question. There were none. She thanked Willis Towers Watson for being in attendance, although time did not permit its material to be presented, and suggested that the Commission will hear it next time.

The Chair asked for a motion to adjourn. All were in favor. The meeting was adjourned at 11:40 a.m.

Respectfully submitted,

Roberta Herman, M.D.
Executive Director

APPENDIX A

Materials distributed at the November 1, 2018 Commission Meeting

1. October 6, 2018 Meeting Minutes
2. Commission Meeting Package – October 4, 2018