GIC COMMISSION MEETING
Thursday, November 21, 2019
8:30 A.M. – 11:00 A.M.

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

MINUTES OF THE MEETING

NUMBER: Six Hundred Forty-seven
DATE: November 21, 2019
TIME: 8:30 a.m.
PLACE: John W. McCormack Building, Conference Rooms 1 & 2, 21st Floor, 1 Ashburton Place, Boston, MA 02108

Members Present:

VALERIE SULLIVAN (Chair, Public Member)

MICHAEL HEFFERNAN (Secretary of ANF) Designee Bill McNamara

GARY ANDERSON (Commissioner of Insurance) Designee Matt Veno

TAMARA P. DAVIS (Public Member)

EILEEN P. MCANNENY (Public Member)

CHRISTINE HAYES CLINARD, ESQ. (Public Member)

TIMOTHY D. SULLIVAN (Massachusetts Teachers Association)

JOSEPH GENTILE (AFL-CIO, Public Safety Member)

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

BOBBI KAPLAN (Vice Chair, NAGE)

EDWARD T. CHOATE (Public Member)

JANE EDMONDS (Retiree)

ANNA SINAIKO, Ph.D. (Health Economist)

ELIZABETH CHABOT (NAGE)

Absent:

MELISSA MURPHY-RODRIGUES (Town of Sudbury--Massachusetts Municipal Association)

KEVIN DRAKE (Council 93, AFSCME, AFL-CIO)

Comm. McAnneny arrived at 8:35
Comm. Chapdelaine arrived at 8:38
Comm. T. Sullivan arrived at 8:41

I. Approval of September 19, 2019 Meeting Minutes

The Chair called the Meeting to order at 8:32 a.m. After opening remarks, the Chair asked if there were any questions or comments on the September 19, 2019 meeting minutes. Hearing none, the Chair then asked for a motion to approve the minutes. Vice Chair Kaplan moved to approve the minutes seconded by Designee Veno. The motion passed unanimously. The Chair then greeted the Executive Director and asked for her report.

II. Director's Report

The Executive Director welcomed the Commissioners and provided an overview of the Meeting agenda before providing her report.

- Review of Commission Calendar

The Executive Director reviewed the calendar of Commission meetings, noted that September's meeting focused on pharmacy and pharmacy benefit managers, noted the break in October and discussed the subjects for the Commission's review in the five meetings taking place from November through February. She explained the work the GIC was performing concerning the annual rate-renewal process, including reviewing proposed plan design changes. The Executive Director stated that a vote was requested at this meeting to approve the auditing services for health care claims processing and that a vote will be requested at the December meeting to approve the recommendation for the apparent successful bidder for a life and long-term disability consultant. She also stated that the GIC would build upon this year's success by continuing its public meetings and labor summit initiatives. The Executive Director stated that a follow-up meeting from the previous meeting with labor would take place in mid-January and that the dates for the public meeting should be finalized in advance of the Commission's December meeting. She described the input received by the GIC's constituencies, noted the collaboration with these constituencies in planning future meetings, and stated that the GIC is taking steps to make these meetings regularly scheduled events.

The Chair stated her approval of the continuance of both the labor and public meetings. In response to questions from the Commissioners concerning the public listening sessions, the GIC's Chief of Staff, Joan Matsumoto, stated that dates have not been finalized and that the location of the meetings were taking place in five distinct geographic areas across the state in order to make attending easier for the GIC's constituents. In response to a question from Vice Chair Kaplan, the Chair stated that the GIC would make sure the Commissioners are aware of the dates and times of the public listening sessions as soon as such information was available and that the GIC would inform the Commissioners about their meeting with labor. Commissioner Clinard asked if the labor summit meetings were open to Commissioners. The Executive Director responded that, typically, such meetings were only attended by the GIC staff and explained that the meeting was designed to foster better understanding about how the GIC works. Vice Chair Kaplan stated that it was not a public meeting, and that these meeting were designed to for unions to meet with the GIC staff. Vice Chair Kaplan also stated that these meetings were important due to the fact that the vast majority of the GIC's constituents were unionized employees. Commissioner Edmunds stated that there would be a benefit in allowing Commissioners to attend. The Chief of Staff stated that the meeting was requested by union leadership and that the meeting was not a public meeting. The Chief of Staff also stated that the GIC would be happy to request that union leadership allow Commissioners to attend, but that decision was ultimately up to union leadership. The Chief of Staff explained the difference between a public meeting pursuant to the state's open meeting law and a meeting that was not open to the public.

- Overview of the Annual Stewardship Meetings

The Executive Director discussed the GIC's annual meeting with insurance vendors noting that the GIC has met with 13 vendors over an eight-week period which concluded on November 14th. She stated that the GIC staff has not yet had enough time to assimilate all the information provided by the vendors for the annual plan review but would be prepared to summarize in December. The Executive Director explained that vendor meetings allowed the GIC to assess vendor performance as well as allow vendors to provide a narrative about their performance. She stated that every vendor reported material cost increases driven more by price than utilization and that this was consistent with patterns demonstrated recently by the Center for Health Information ("CHIA") and the Health Policy Commission. The Executive Director noted that top health care conditions by cost among GIC members are consistently diabetes, cancer, behavioral health, and musculoskeletal issues. She stated that costs associated with chemotherapy and specialty drugs are skyrocketing, and noted that one life-saving Zolgesma treatment for spinal atrophy cost $2.1 million. The Executive Director noted that inpatient and emergency room care had particularly high increases across all plans and might be driven at least in part by billing practices designed to maximize

revenue, as also noted by CHIA and the Massachusetts Health Policy Commission ("HPC".) She stated that while it is too soon to determine, she could not rule out a potential recommendation to freeze enrollment for one or more plans or products for FY21. She then discussed action plans the GIC will present to vendors in order to manage costs and explained how certain benefits should offset costs. In response to a question from Commissioner Choate about whether the GIC presents vendors with a report card of their performance based on cumulative data, the Executive Director discussed the GIC's vendor review process and noted that while cumulative data is important, it is equally important for the GIC not to come to conclusions based on micro trends and explained how such trends may not be applicable to the GIC and its members.

The Executive Director then discussed two informational items not related to the annual stewardship meetings. She stated that Beacon Health Options and UniCare completed their claims processing integration and automation, and that behavioral health claims were under control. The Executive Director also stated that, at the request of MassRetirees, the GIC solicited bids to increase basic life insurance from $5,000 to $10,000 and researched what it might require to enable retirees who are not Medicare eligible because they were hired before 1984 and not required to contribute to Social Security to obtain Medicare benefits. She stated that the GIC will be meeting with Shawn Duhamel, Chief Executive Officer of MassRetirees, to share the GIC's findings.

- State Audit related to Pharmacy Benefit Managers

The Executive Director informed the Commissioners that the Office of the State Auditor is conducting an audit of pharmacy benefit managers contracting with the GIC from July 2017 forward. She stated that the scope of the audit is broader than the GIC, but will require the GIC to comply with document requests and to meet with the Office of the State Auditor on a regular basis until a report is issued.

- Flu Campaign

The Executive Director noted that it conducted a flu-shot campaign in two state buildings which served the dual purpose of administering vaccine but, as important, reminding state employees to obtain a flu shot from one of many venues in the community. She explained how the flu can have a detrimental effect on the workforce and how a simple flu shot is still among the most impactful available medical and public interventions. In response to questions from the Commission, the Executive Director noted locations where the flu shot

was administered and the GIC's Director of Marketing and Communication, Linnea Walsh, stated that over 200 flu shots were administered.

- Space Planning – Redevelopment of the Hurley Building

The Executive Director explained that, in conjunction with the planned redevelopment of the Hurley Building, the GIC plans to move to the McCormack Building near the end of 2021. She discussed the design and potential benefits of the new space and stated that it was an extremely promising development.

- Legislative Update

The Executive Director informed the Commissioners that the Governor filed comprehensive health care legislation designed to improve outcomes for patients, increase access to care, and bring down overall costs. She stated that the legislation had two main focus areas: prioritize investments in primary care and behavioral health within the cost growth benchmark; and manage health care cost drivers to protect consumers. The Executive Director explained that there are a lot of activities within the legislation to monitor and that the GIC would keep them appraised of the legislation. She then informed the Commissioners that the Massachusetts Senate recently passed legislation designed to address pharmaceutical access, costs, and transparency. The Executive Director then asked Designee Veno if he had anything to add. Designee Veno stated that the Governor's proposed legislation had language to address growing prescription drug costs and that, while some of the language differs from the Senate's legislation, the prescription drug language was similar. He stated that the greatest similarity between the Governor's and the Senate's proposals is that both pieces of legislation were aligned in strategy in order to reduce prescription drug costs. He then discussed how the Governor's legislation created a role for the HPC and explained that the HPC was already drafting regulations in anticipation of a successful bill. He also informed the Commissioners that the Massachusetts House of Representatives had filed a bill to challenge the Governor's health care legislation and that he expects a similar challenge from the Senate.

The Executive Director then informed the Commissioners about the December 1 statutory deadline for municipalities and regional school districts to notify the GIC of their intent to re-enroll or withdraw from the GIC's insurance program. She stated that, while there are two weeks until the deadline, 25 of the 26 municipal organizations up for renewal had decided to stay with the GIC and 1 decision is still outstanding. Designee Veno stated that those retention numbers were remarkable. The Executive Director recognized the GIC's

Director of Legislative Affairs, Michael Berry and the GIC's Chief Financial Officer, James Rust, for their hard work with municipal engagement. She explained that the GIC had 11 face-to-face meetings with municipal leaders, eight of which were enrolled with the GIC and three who were assessing the GIC as a viable insurance option. The Chair stated that the retention rate was a strong endorsement for the GIC. The Executive director then answered questions and responded to suggestions from the Commissioners concerning the GIC's annual stewardship meetings and public outreach initiatives. A discussion ensued and, at its conclusion, the Executive Director thanked the Commissioners for their recommendations.

III. Highlights from the Cost Trend Hearings

The Executive Director then welcomed Ray Campbell, Executive Director of CHIA, and David Seltz, Executive Director of the HPC, and informed the board that they would be providing their annual presentations to the Commissioners, highlighting data provided at the 2019 Health Care Cost Trend Hearings, and discussing where the GIC's falls within the commercial insurance trends. She informed the Commissioners that while the data clearly shows that costs are increasing universally, the impact of those costs is disproportionate. The Executive Director explained that the burden of rising costs are distributed differently across market segments with employees, unsubsidized individual purchasers, and small group employer-sponsored plans bearing the brunt of cost increases. She noted that September's meeting had covered the rising costs of prescription drug prices; this meeting will also highlight increasing costs in other areas of the health care industry and emphasize unit cost and price variations that will continue to challenge the GIC and the market. She stated that the data made it clear that healthcare cost increases were becoming unsustainable, even for middle income Americans. The Executive Director then introduced Ray Campbell and asked him to present his report.

Mr. Campbell greeted the Commissioners and explained that the presentation was designed to highlight data from the CHIA's Annual Report published in October. He stated that the Annual Report was an incredible compendium of important information. He explained that his presentation could not do the Annual Report justice because of the significance of the both data presented and the underlying data, and the important implications such data represents. Mr. Campbell noted that Massachusetts is the only state that aggregates and publishes a report on an annual basis. He discussed the value of data aggregation across all health care populations, including Medicare and Health Connecter populations in addition to commercially insured populations, and noted that the Annual Report focuses on financial data. Mr. Campbell explained that each slide represented comprehensive data on the

health care system gleaned from the Annual Report and that the Annual Report was available on CHIA's web site.

Mr. Campbell explained that the data represented in the slides was from the Annual Report and that the Annual Report contained the 2017 total health care expenditures (THCE) in Massachusetts and an initial calculation of 2018 THCE. Referencing his presentation, Mr. Campbell noted that total health care expenditures were $60.9 billion, up 3.1% from the prior year with an $8,827 THCE per capita. He stated that Massachusetts had historically performed better than the benchmark except for 2014 and 2015 when the implementation of the Affordable Care Act was taking place. Mr. Campbell referenced the total health care expenditures by components and explained that the graph showed who was paying for the $60.9 billion of overall spending in 2018 and the size of the different markets. He noted which components were trending above or below the benchmark and stated that Massachusetts would have had significantly better performance but for the Medicare component going over the benchmark. Mr. Campbell stated that the net cost of private health insurance (NCPHI) rose 11.3% and explained that this was the second year in a row NCPHI had a double-digit increase. He extrapolated that large increases in small plans may be due to additional administrative costs. Mr. Campbell then answered questions from The Chair and Commissioner McAnneny concerning administrative costs and whether certain costs are double counted or are net potential rebates. Mr. Campbell referenced total health care expenditures by service category and reviewed the expenditures in hospital inpatient and outpatient services, gross and net-of rebates pharmacy services, and physician and other services.

Mr. Campbell stated that the remainder of the presentation focused on commercial insurance and he noted that there had been $23.3 billion in expenditures which represented a 3.3% annual increase. He also noted member months were down slightly at 0.06%. He then discussed trends by market segment and stakeholder from 2016 through 2018, and noted that, as the Executive Director had stated, the experience of individuals is not the same. Mr. Campbell stated that member cost-sharing and premiums increased at a faster rate than wages and inflation. He said that while cost growth trends appeared steady, rising at around 3% annually, cost sharing was up 12% over the past two years and premiums were up over 10% for the past two years. Mr. Campbell discussed how disproportionate this increase was on a per capita basis and extrapolated on the financial impact on individuals and families. In response to a question from the Chair regarding how out-of-pocket data is obtained, Mr. Campbell stated that CHIA obtains its data directly from commercial insurance companies and discussed how the information is categorized and presented in CHIA's Annual Report. Mr. Seltz also provided insight on the collection of aggregate versus individual data.

Mr. Campbell then discussed enrollment by market sector and noted that while the jumbo group employer sponsored insurance plans represented over 56% of the commercial marketplace, enrollment in those plans declined by 4% in 2018. He also noted enrollment declines in the GIC, mid- and small-group employer sponsored insurance plans. Mr. Campbell stated that while 93% of members were covered by employer-sponsored insurance in 2018, individual purchasers continued to show the fastest percentage growth in enrollment. He then referenced the enrollment by market sector and product type, and explained that members of larger employer groups tended to enroll in PPO and POS plans, while smaller employer groups and individual purchasers favored HMO plans. In response to a question from Commissioner Choate regarding the similarity in the number of members but the disparity in product types between other purchasers and the GIC, Mr. Campbell agreed that the GIC has heavy enrollment in HMO, POS and Indemnity products compared to other large employers where PPO dominates.

Mr. Campbell then reviewed enrollment by market segment and funding type and explained that the graph was showing that, typically, the larger the group, the more likely the plan was self-insured. He noted that individual purchasers and small groups were almost entirely fully-insured. Mr. Campbell stated that over 60% of commercial members were enrolled in self-insured plans and noted that the GIC was primarily self-insured. The Executive Director added that currently, with the exception of the Medicare Advantage plan, the GIC is entirely self-insured. Mr. Campbell then reviewed the largest payers by market sector and stated that each market sector was typically dominated by three insurers but they were not always the same insurers in each sector.

Mr. Campbell then reviewed high-deductible health plans by market sector and stated that while it was not applicable to the GIC, which has no high-deductible plans, it was interesting in that the growth of high-deductible plans now represent 31.5% of the market, almost 1/3 of the health care insurance market. He explained how such plans impacted health care data, including cost sharing and member spending. Mr. Campbell explained that high-deductible health plans were purchased by 80.2% of the unsubsidized individual purchasers and, although the percentage of purchasers were smaller in larger size plans, the number of purchasers in the jumbo group was significant. Designee Veno asked if the data accumulated by CHIA includes reimbursements to individuals that may be available from flex-spending accounts or health reimbursement accounts. Mr. Campbell stated that CHIA's data does not encapsulate such data and described how CHIA obtains individual data through surveys, but reimbursement data is not collected or reflected in the Annual Report. Designee Veno stated that such accounts, especially in high-deductible health plans, help individuals manage health care costs and having that data would be useful. Commissioner Sinaiko stated that many people do not know they have such tools at their disposal to

manage health care costs or they choose not to use those tools. The Executive Director noted that the GIC offers a flexible spending account and that participation levels are low despite the GIC's efforts to make members aware that the flexible spending account exists.

Mr. Campbell then reviewed enrollment by benefit design and stated that while enrollment in high deductible health plans continued to grow, adoption of tiered and limited networks remained flat and discussed possible reasons for these trends. He also noted that the GIC enrollment was split with 70% tiered and 30% limited network. Mr. Campbell discussed fully-insured premiums by market sector and noted the clear correlation between size and premium amounts on a per member per month ("PMPM") basis. He discussed the year-over-year changes and explained that, while they are not always correlated with the size of the plan, individual purchaser premiums through ConnectorCare increased 22% in 2018 while the average increase across all sectors was 5.6%. Mr. Campbell noted that the GIC premiums went down 1.1% in 2018 and complimented the GIC. Mr. Campbell then noted that average monthly premium in 2018 was $509, which was also the GIC's average monthly premium. The Executive Director discussed the GIC's average monthly premium and reduction in premiums, and pointed out that the monthly premium average does not reflect the richer level of benefits the GIC offers its members compared to other market sectors. Designee Veno stated that it would be interesting to see the actuarial value in order to show correlations among insured group, actuarial risk-value, and cost-benefit information. Mr. Campbell stated that fully-insured benefit levels by market sector cover that to some extent, but not as explicitly as suggested. He stated that the Annual Report contains cost sharing by market sector, out of pocket expenses by member, as well as individual purchaser information and that the materials referenced for this data in the Annual Report may contain actuarial values and risk information.

Mr. Campbell then reviewed fully-insured benefit levels by market sector noting the premiums per member per month and the percentage of fully-insured medical claims costs paid by the plans versus those paid by members. He noted that the GIC was doing an excellent job for its members, covering 92% of claim costs, which was higher than all non-state subsidized plans. He then discussed cost-sharing by market sector and explained that it was reported on both a monthly and yearly basis per member. He stated that this information was provided by health plans which separated their payments from member payments. Mr. Campbell noted that unsubsidized individual purchasers were paying the most and that their cost sharing was increasing the fastest. He provided an example of a family of three paying $3,330 out of pocket per year and noted the impact of that cost on a household budget. Mr. Campbell then explained the year-over-year increases in mid, large, and jumbo group plans, and the per member cost sharing noting that the GIC was in line with large group plans. Commissioner McAnneny asked whether cost-sharing data

distinguished between amounts paid and amounts owed to health care providers. Mr. Campbell stated that the data was on a claim basis, not the amount paid and that it did not include bad debt. He did note that data on bad debt should be available at hospitals, but such data was not requested by CHIA. After a brief discussion on how CHIA collects and reports data, the differences between CHIA and HPC, Mr. Campbell asked the Commissioners if they had any questions. There being none, he concluded his report.

The Chair thanked Mr. Campbell for his report. The Executive Director stated that Massachusetts was fortunate to have CHIA and the HPC and expressed her gratitude that such information was aggregated and made available to the public. She then introduced David Seltz and asked him to provide his report.

Mr. Seltz greeted the Commissioners and provided background on the HPC, discussing the HPC's mission, goals, and reporting structure. He discussed the differences between HPC and CHIA, noting that while CHIA was a data collection agency with a public interest perspective, the HPC used the data CHIA collects to provide policy recommendations regarding health care delivery and payment system reform. Mr. Seltz noted that the GIC is one of the state agencies he works closely with and that the HPC and the GIC have shared goals. He discussed the HPC's roles in both the annual Health Care Cost Trend Hearings and proposed health care legislation, and predicted a busy and impactful year ahead. Mr. Seltz stated that his report would highlight the HPC's presentation at the Health Care Cost Trends hearing and that, in the interest of time, he would skip certain parts of the presentation.

Mr. Seltz stated that since 2009, total health care spending growth in Massachusetts has been below the national rate. He added that in 2009, Massachusetts had the highest per person health care spending in the United States which was 36% higher than the national average. He stated that Massachusetts now ranks second. Mr. Seltz noted that elective surgery not covered by insurance is not included in the data and explained the factors that contribute Massachusetts' ranking, noting that Massachusetts has both a higher average income and a higher average age than most states. Mr. Seltz explained that the HPC performed an analysis on these numbers and found that age and wealth accounted for 15% of the 36% overage. In response to questions from the Commissioners, he stated that wealthy households can have a disproportionate impact on the averages and explained how high net worth households were more likely to pay more for high-cost surgery and high-cost hospitals.

Mr. Seltz then reviewed Massachusetts inpatient hospital admission rates and noted that while they are historically above the national average, they have been flat since 2014. He explained that there was a big shift in where care was being administered and that inpatient

care was decreasing. Mr. Seltz then discussed discharge rates over the previous five-year period and noted that Medicare discharges have increased while commercial inpatient discharges have decreased. He noted that the increase associated with Medicare was largely due to the aging population and explained how hospitals were adjusting to this trend. Mr. Seltz also discussed how the decreasing volume of commercially insured inpatients was impacting hospitals.

Mr. Seltz then noted there has been an increase in patients who receive care at home after being discharged and a corresponding decrease in institutional post-acute care. He added that this trend should continue as in-home care options increase. Commissioner Sinaiko stated that in-home care has been highly successful because of its lower costs and because patients prefer it. Mr. Seltz then responded to a question from Commissioner McAnneny regarding where post-discharge care costs fall in total health care expenditures. He also responded to questions from The Chair concerning the trends presented. He explained that the use of hospitals is decreasing for several reasons, notably a declining birth rate and the proliferation of day surgeries. Mr. Seltz stated that the data showed an interesting phenomenon: as hospital utilization declined, commercial insurance inpatient spending increased at nearly identical, corresponding percentages. He stated that it is implausible that Massachusetts suddenly has sicker patients, but offered a possible explanation based on better medical record keeping through electronic systems and providers' efforts to capture the complexity of a patient's diagnosis.

In response to a question from Commissioner Edmonds, Mr. Seltz discussed the aging population's impact on health care spending and noted that Medicare spending in Massachusetts is growing faster in most categories when compared to the national averages as shown on pages 35 and 36 of the Meeting materials. He also noted that the use of teaching hospitals can have an impact on Medicare spending because Massachusetts has more teaching hospitals and because 40% of hospital stays are at teaching hospitals. He also noted that that people in Massachusetts simply use hospitals more than people in other states. In response to a question from Vice Chair Kaplan concerning whether behavioral health was contributing to the increase in hospital costs, Mr. Seltz stated that there was a data gap in that the data only represented acute care hospitals, not psychiatric hospitals. He did note that while the volume of commercially insured hospitalizations was decreasing, Medicaid hospitalizations were increasing, primarily due to the opioid crisis. Mr. Seltz also responded to questions from Commissioner McAnneny and Vice Chair Kaplan concerning other factors that may have led to the increases in Medicare spending and whether ease of access to hospitals contributes to above average utilization in Massachusetts, respectively.

Mr. Seltz then reviewed commercial medical spending growth in Massachusetts and noted that it was under the national average since 2013, which was shortly after the HPC was established. Mr. Seltz then reviewed the slide that showed commercial inpatient spending increasing 11% while the volume of inpatients fell 14% between 2013 and 2018, and discussed the implications of this slide, especially with regard to the collective public and private alignment to slow the growing cost of health care.

Mr. Seltz then reviewed spending by the top three payers from 2016 through 2018 and noted that increases in unit price was the primary reason behind the increase in spending by commercial plans and explained the contribution of utilization and provider and/or service mix to spending growth. He then discussed per member spending by provider system from 2013 to 2018. He reviewed the underlying data and stated that the health care system your doctor is a part of impacts the total cost of the health care provided. He stated that Atrius Health's physician networks do a better job of managing the costs of their patient population than larger providers. The Executive Director stated that this type of analysis is part of the GIC's mission and described the impact of industry consolidation. She stated that the GIC relies on this data in its decision making process. Mr. Seltz discussed the HCP's role in analyzing data to determine how different providers manage care and the cost of care.

Mr. Seltz then reviewed how many dollars per household went to health care between 2016 and 2018, noting that nearly $0.40 of every dollar earned by Massachusetts families went to health care. He stated that health care cost are greater than taxes and noted that health care spending for Massachusetts families with employer-sponsored coverage exceeded $2,000 per month in 2018. Mr. Seltz then reviewed the percentage of earnings spent by middle-class families on health care and discussed high-burden families, which are families that spend more than a quarter of their earnings on health care. He stated further that one of the HPC's goals is to reduce the average amount of health care spending per household in order to increase the take home income which, in return, will have a better impact on the economy. Mr. Seltz then discussed inefficiencies associated with health care administration and its detrimental impact on care and cost of care. He then answered questions from Commissioners concerning, among other topics, how focusing on costs only tells part of the story and oversimplifies the complexity of the health care system, the data behind high-burden families, and the difference between effective health care administration and unessential administration. Mr. Seltz concluded by discussing the Governor's proposed health care legislation, the HPC's efforts in determining the price and efficacy of prescription drugs, and the urgency behind the HPC's efforts to prevent greater annual increases in health care costs. The Executive Director thanked Mr. Seltz for his report.

IV. CFO Update

- FY2020 First Quarter Financial Performance Report

The Chair welcomed the Chief Financial Officer ("CFO"), James Rust, and asked for his report. The CFO then reviewed expenses payable by the Commonwealth of Massachusetts for all accounts, including health care, life, disability, dental, and administrative expenses from July through October. He reviewed the employees' share for all accounts for the same period. The CFO reviewed the claims budget for all accounts versus the actual claims paid amounts on a month-by-month basis from July through October, noted that budgeted spending and actual spending were in in line, and discussed the seasonality of claims and actuarial projections. He then presented the claims budgeted for all accounts versus the actual claim amounts on a cumulative basis and noted that fiscal year projections show predicted monthly variations. The CFO then presented the budget for all accounts on a cumulative basis and stated that budgeted and actual amounts are in line with one another for the first four months of the current fiscal year ending October 2019. He stated that the cumulative state share of claim budget for all accounts was an important metric in that it shows how close to budget GIC is to date. The CFO noted that variances in basic life and health were the result of higher utilization but that the variance was essentially in line due to normal volatility. He noted that the dental account was in deficit and would remain so this fiscal year. A&F is aware and will be supplementing the budget in the second half of FY20. He then discussed the entire budget in comparison with the prior fiscal year's results and asked the Commissioners if there were any questions. There being none, the Chair thanked the CFO for his report.

V. Contracts & Amendments

- Audit Recommendation

The Executive Director introduced the GIC's Budget Director, Catherine Moore, and asked her to present the audit recommendation for health care claims processing. The Budget Director stated that the GIC solicits bids from audit firms every four years for the purpose of contracting a firm to audit plan performance and claims payments made by the GIC's vendors to ensure payment was appropriate and correct. She noted that it was not glamorous work, but it was necessary work to ensure fiscal discipline. The Budget Director explained that the GIC's audit team met with four companies as a result of the request-for-response ("RFR") process. She described the RFR process and stated that all firms were qualified, provided quality bids, and each were scored according to a predetermined mechanism. The Budget Director discussed compliance with the Massachusetts RFR

process, required due diligence and explained that vendor costs were not reviewed until a comprehensive qualitative review was completed. She stated that only two firms were in contention at the end of the scoring process and that the GIC was recommending the Commissioners approve Claim Technologies as the GIC's health care claims processing auditor. Vice Chair Kaplan asked how vendors could have such a significant increase in the supplier diversity program ("SDP") score from the initial scoring phase to the final scoring phase, a sentiment shared by multiple Commissioners. The GIC's General Counsel, Andrew Stern, stated that such increases are not uncommon and explained that vendors are often confused by the SDP requirements. He stated that once vendors gain an understanding of Massachusetts diversity laws and the scope of the SDP requirements during the in-person interview phase, their diversity scores can increase dramatically. In response to questions from the Commissioners, the General Counsel described the timing and requirements of the RFR process, and noted that updating the bids is part of the process. He also discussed the required compliance practices that vendors must undertake on an annual basis to ensure compliance with SDP requirements. In response to a question from Designee Veno, the Budget Director stated that the contract would be for an initial two-year term running from January 11, 2020 to June 30, 2021, with a renewal option for the third and fourth years, July 1, 2021 to June 30, 2022 and July 1, 2022 to June 30, 2023, respectively. She also noted the importance of these auditors in that the auditors give health plans information to help them incorporate process improvements, and that the GIC measures these improvements on an annual basis.

There being no further questions, the Chair asked for a motion to approve Claim Technologies as the GIC's Health Care Claims Processing Auditor. The motion was made by Commissioner Choate, seconded by Designee Veno, and unanimously approved.

- Life/LTD Consultant and Data Warehouse Procurement

The General Counsel then provided a procurement update and discussed the combination of a life insurance and long term care consultant. He stated that the GIC is currently meeting with finalists and that he expects they would have a recommendation for the Commissioners at the next meeting. The General Counsel also noted that the procurement of a data warehouse vendor was underway and that the team assembled to review bids expects to receive up to 17 bids by the December 3rd bid deadline. He stated they would update the Commissioners on the procurement status at the next meeting.

VI. GIC Modernization

- myGICLink

The Executive Director then introduced the Director of Operations (DOO), Paul Murphy, and the Chief Information Officer (CIO), John Harney. She explained the exciting new technology initiatives and described how they fit in the GIC's broader strategic initiatives and core strategies. The Executive Director stated that this initiative was part of the foundation of the modernization effort, described the impact that it would have, and explained how technology initiatives will streamline the member experience and make the process easier for members. The Executive Director then asked the CIO and the DOO to provide an update on these technology improvements.

The CIO discussed the status of the different system implementations, and reminded the Commissioners that at the September meeting the process was just starting and now, just two months later, they were two weeks from implementation. He credited many groups and agencies for their help and support with this project, noting that A&F IT Project Manager, Stephanie Sutliff, has been doing a lot of the heavy lifting on this project. The CIO discussed the discovery-and-design phase of the project and explained how it was accomplished by reviewing every possible interaction a member might have with the GIC. He noted that the vendor had gone above and beyond what was required, or even expected. He then played a video for the Commissioners about the technology initiative that was created for the GIC staff. He then introduced the DOO and asked him to continue with the presentation.

The DOO then provided an activities report to the Commissioners, noting that 18 staff members have participated in user acceptance testing and that they created over 100 scenarios with over 400 actions for testing. He stated that these tests resulted in 50 change recommendations from the staff, which were implemented by the development vendor. The DOO explained that certain staff members received a specialized two-day training so they could act as a point of contact for systems related guidance for GIC Coordinators from over 900 member organizations. He also noted that 10 staff members participated in DocuSign user acceptance testing. The DOO stated that going paperless was the main goal. He described other testing and training that took place, provided a timeline for rolling out the process across agencies and municipalities. He stated that, to date, there had been no issues, but it is always a possibility and not unexpected. The DOO also noted that the vendor had been assisting and will continue to assist as the system goes live. In response to a question by the Chair, the DOO stated that the implementation timeline was designed to have GIC's members use the new technology during the enrollment period. The Executive Director stated that she was thrilled at the progress being made and was amazed at the

pace of the rollout. The Commissioners then applauded. The Vice Chair stated how amazing it was to witness the steps the GIC was taking on its way to becoming paperless.

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

The Chair asked if there was any additional business before the Commissioners, there being none, she made a motion to adjourn, seconded by the Vice Chair, which was unanimously approved. The Meeting adjourned at 11:05 AM.

Respectfully submitted,

Joan M. Matsumoto

Joan Matsumoto
Interim Executive Director

APPENDIX A

Materials Distributed at or prior to the November 21, 2019 Commission Meeting

1. An Act To Improve Health Care by Investing in VALUE (two-page summary)
2. Auditing Services for Health Care Claims Processing