GROUP INSURANCE COMMISSION MEETING
Thursday, May 16, 2024
8:30 A.M.-10:00 A.M.

Meeting held virtually through online audio-video platform (ZOOM) and accessible on the GIC's YouTube channel.

MINUTES OF THE MEETING

NUMBER: Six hundred and eighty-one
DATE: May 16, 2024
TIME: 8:30 A.M.
PLACE: Meeting held virtually through online audio-video platform (ZOOM) and accessible on the GIC's YouTube channel

Commissioners Present:
VALERIE SULLIVAN (Chair, Public Member)
BOBBI KAPLAN (Vice Chair, NAGE)
MATTHEW GORZKOWICZ (Secretary of Administration and Finance) Designee: Dana Sullivan
GARY ANDERSON (Commissioner of Insurance) Designee: Rebecca Butler
JOSEPH GENTILE (AFL-CIO, Public Safety Member)
TIMOTHY D. SULLIVAN (Massachusetts Teachers Association)
EDWARD T. CHOATE (Public Member)
TAMARA P. DAVIS (Public Member)
EILEEN P. MCANNENY (Public Member) - joined late at 9:06 A.M.
PATRICIA JENNINGS (Public Member)
JASON SILVA (Massachusetts Municipal Association)
MELISSA MURPHY-RODRIGUEZ (Massachusetts Municipal Association)
ANNA SINAIKO, Ph.D. (Health Economist)
ELIZABETH CHABOT (NAGE)
JANE EDMONDS (Retiree)
GERZINO GUIRAND (Council 93, AFSCME, AFL-CIO)

At 8:30 A.M. Chairperson Valerie Sullivan gave opening remarks.

Agenda Review

Executive Director Matthew Veno provided an overview of the agenda.

Minutes

The Chair asked for a motion to approve the Minutes from the prior Commission meeting. Vice Chair Kaplan moved. Commissioner McAnneny seconded. The General Counsel took a roll call vote. The motion passed unanimously, with Commissioner Jennings abstaining.

Executive Director's Report

The Executive Director provided highlights to his written report. He provided an overview of staff changes and legislation. He mentioned that there is a new health care bill before the legislature. He also noted that the Shore Collaborative had been successfully onboarded into GIC benefits.

Chair Sullivan asked if he could provide highlights of the proposed health care bill.

The Executive Director noted that there's a lot of policy changes to prevent the same situation of what happened with Steward Health Care from happening again, particularly related private equity in health care. The bill also would change how the Health Policy Commission (HPC) determines the Health Care Cost Growth Benchmark. The bill would also move the existing state health system planning function from the Department of Public Health to the HPC. Other provisions aim to bring more clarity around closures of health care facilities. GIC is paying close attention to the cost growth benchmark since performance guarantees in our health plan contracts are tied to the benchmark.

Commissioner Eileen McAnneny voiced concern over the bill's proposed removal of the purchasers seat on the HPC board. The bill would permit the HPC to set the benchmark above or below the current one, which she also found concerning. There also is a rate floor for historically low reimbursement providers but not a corresponding ceiling, which she is concerned will only increase costs.

Vice Chair Kaplan asked whether the GIC anticipates any challenges with getting their budget approved. She also inquired about how many additional municipal members were added from the addition of the Shore Collaborative. Commissioner Choate also asked what the year-over-year increase for budget has been for the GIC.

The Chief Financial Officer (CFO), James Rust, stated that he is confident in his budget predictions and that the budget should be approved as requested. He also noted that the year over year increase is about 7-8.5%.

The Executive Director noted that there were 140 new GIC members from the Shore Collaborative, including 25 retirees. He continued by noting that next month the Commission will report on annual enrollment. The backend work is substantial, he continued, and will not be finished for a few more weeks. He further noted that Annual Enrollment went smoothly this year. 4,300 members switched plans which is typical. Use of the MyGICLink member portal continues to increase as most changes were made through that platform. He also noted that Executive Director of CHIA, Lauren Peters, will present at the next meeting on prescription drug costs. The GIC will make a recommendation for a dental and vision benefits consultant in June. He finished stating that the Commission should expect to have at least one in-person meeting in the Fall.

Out-of-pocket Report

The Executive Director passed the meeting to Lauren Makishima, Data Analytics Manager, to present the out-of-pocket report for FY23 (July 2022-June 2023, which is prior to the most recent medical and pharmacy procurements). Ms. Makishima stated that the goals for the presentation will explore trends

in out-of-pocket costs; how those costs compare to state and industry benchmarks; and explore reasons why some members might experience or incur more out-of-pocket costs. She provided an overview of what constitutes out-of-pocket costs and how they are defined for this report. She noted missing data in FY19 and FY20 and explained that it is due to the GIC making improvements on how out-of-pocket costs are tracked and reported for Medicare. She continued that those algorithms couldn't be applied to FY19 and FY20. She stated that FY23 out-of-pocket costs increased 3.95% for Non-Medicare and 4.5% for Medicare from the prior year. There were significant population shifts, she noted, so a more accurate look would be to use the units of per member per month (PMPM) in the analysis. Non-Medicare out-of-pocket costs measured in PMPM increased $2.98 for medical and $1.80 for prescription drugs. There are dips in FY20 and FY21 due to the pandemic. Telehealth services were also waived during those years, she explained, which also accounted for the changes.

GIC members surveyed preferred to pay more in premiums than out-of-pocket costs and that is part of why members have been protected from higher out-of-pocket costs. That said, she continued, medical costs have skyrocketed. Out-of-pocket cost increases for non-Medicare prescription drug out-of-pocket costs were over 6% over the last few years. Increasing use of GLP-1 drugs for diabetes and weight loss are just one factor driving up costs, she said. GIC has covered an increasing portion of costs as health care costs have risen. As medical and prescription drug costs have risen, the GIC has covered 2.6% more of the total cost over the last 5 years.

GIC members pay around 8% of total health care cost, out-of-pocket. This is below the average of WTW's Benchmarking Study, she noted, with the average in the benchmarking survey being 15% of total health care costs. Generally, GIC members have lower average out-of-pocket costs than other large employers, she said.

Next, Ms. Makishima discussed why some members incur high out-of-pocket costs. The median out-of-pocket costs per household was $960/year in FY23 (up from $907.00 from the previous year) for GIC members. Those numbers are for both Medicare and non-Medicare members and also included prescription drugs. Factors that can influence or cause high out-of-pocket costs include: out-of-network provider use, non-covered services, prescription drug "penalties" (e.g. the member uses brand name where a generic is available and they're responsible for the balance of costs; member continued to refill a one-month supply at an in-person pharmacy where a three-month supply can be obtained through mail order, etc.), among others. Regarding prescription drugs, the total may not be a true reflection of out-of-pocket costs because some members obtain coupons (providing the member with a point-of-service discount) for medications and these coupons aren't reported back to the Pharmacy Benefits Manager and therefore aren't in the analysis.

The number of households with $5,000-$9,999 in out-of-pocket costs increased from 3642 in FY22 to 4081 in FY23. Households with more than $10,000 of yearly out-of-pocket costs increased by 197 between FY22 and FY23. In preparing the report, the GIC requests information from its carriers on members who incur high out-of-pocket costs. Seventy-one members had high out-of-pocket costs, 25 of whom used in-network providers and 46 of whom used out-of-network providers. Of those 71 members, around three quarters were offered care management services, but only 28% of them opted into care management. Care management services help members navigate their care and also help them keep costs down as much as possible. Regarding prescription costs that were high, 32 members fell into this category, many of whom were penalized for retail refills when a 3-month mail order could

be obtained, and a number of these members also incurred product selection penalties (choosing brand name over generic or other “equivalent” medications).

Vice Chair Kaplan spoke about the heavy burden the $75 copays places on members. She also noted that she thought when the GIC switched from Express Scripts to Caremark, many members who were on stable meds moved to higher copays.

Commissioner Choate asked about the prior authorization process for GLP-1 medications.

Ms. Makishima stated that while she did not have that information on hand, it would be provided at a future meeting.

The chair echoed the question about GLP-1 prior authorizations.

Commissioner Choate asked if there were other medications that have prior authorizations.

The Executive Director affirmed that there are many medications with prior authorization requirements.

The Vice Chair asked of the number of prior authorizations that were rejected, how many submitted appeals, and what were the disposition of those appeals. She asked for this information for all specialty drugs, as she is concerned about people not getting their medications in a timely manner.

Commissioner McAnneny said that CVS Caremark presented recently at a conference on the new GLP-1 drugs and their presentation emphasized that treatment with GLP-1 medication needs to have other treatments and interventions for it to be successful long term.

The Executive Director assured the Commission that there is not widespread denial of care that is not supported by the evidence, noting that utilization management tools are highly regulated and monitored in order to balance coverage for evidence-based treatment and timely care with managing costs.

Reduced Waiting Period (RWP) Report

The Chair turned the meeting to the Deputy Executive Director, Erika Scibelli, and General Counsel, Andrew Stern, to present on the reduced waiting period (RWP) for benefits. The Deputy Executive Director stated that the waiting period is planned to go live on July 1, 2024. This change will reduce the average waiting period for benefits from 73 days to 15 days, which is roughly 80%. She noted that anyone hired before July 1, 2024 will remain subject to the current minimum waiting period policy, without exception. She said that the GIC has been developing internal reporting and systems and working with carriers, and are updating the GIC’s regulations to reflect these changes.

The Vice Chair thanked the GIC for taking this on and getting it done, noting that it entails a lot of work. She then asked, for new hires, how long they now have to select an insurance plan.

The Deputy Executive Director said new hires will still have 21 days to make elections. The bill will not go out right away, she continued, but will soon be in the portal where the member can go pay it. She noted that the GIC has made efforts to foster information sharing on the new changes, including creating a dedicated set of coordinator trainings for the reduced waiting period.

The General Counsel updated the Commission on the regulatory change process to reflect the reduced waiting period changes. A draft was given to the Commission in December, he said, and the Commission

voted to move forward with the promulgation process. The draft has been published on the GIC's website and a comment period was provided. Additionally, a public meeting was held to solicit feedback on the proposed changes. No comments were provided at those hearings. The final draft, he stated, was in the Commissioner's meeting packets. He said the Commissioners would be asked for a motion and vote to approve the final draft. After approval, he continued, it will be submitted for review and publication to the Secretary of State.

The Chair asked what the total increase in costs will be for the change and if the current budget request included that amount.

The CFO answered that the costs have been known for quite a while and are rolled into the current budget request. He noted that as a self-insured entity, the GIC will pay somewhere between $10-12M in incremental new costs.

The Vice Chair made the motion to approve the regulatory changes and Commissioner Chabot seconded the motion. The General Counsel took roll call vote and the motion passed unanimously.

Trust Funds

The CFO presented made a request for authorization to spend trust fund dollars. These funds, he stated, would be used only if the administrative budget is insufficient or if new projects come up that were not anticipated. He said that there is a process of how these projects must be approved. The last few years, he continued, the GIC has not needed to use the trust fund money, but the preauthorization that is requested allows the GIC to address needs if they come up throughout the year. He underscored that again this year the GIC does not anticipate that it will use the funding, but this authorization provides the GIC the flexibility should the need arise.

The Vice Chair noted that there may be an mistake in the charts provided.

The CFO acknowledged that the Business Continuity amount listed in FY24 should be $100,000, not $80,000, accounting for the discrepancy. He reiterated that the request is for level funding and noted that if money were to be used, the commission would be provided with a summary of information on the use. He noted that the GIC does not currently have any temporary employees, but the GIC always requests authorization to hire up to ten in case there's a surge in work.

Commissioner Edmonds made a motion to approve the request, as clarified, and Commissioner Chabot seconded the motion. The General Counsel took a roll call vote. The motion passed unanimously.

CFO Report

The CFO then gave the CFO report. The spending in April, he said, increased substantially both on the vendor and the employee expense share. Currently, he noted, the GIC is $14M underbudget but that amount is only 0.6% of our budget. He remarked that spending is closely tracking with the overall budget estimated for this year.

Old/New Business

The Chair called for any other business.

The CFO then gave a brief update on procurements. He said that the GIC is ahead of schedule on the dental and vision consulting procurement, which would allow the GIC to start the actual vendor procurement in the Fall. He stated that the data warehouse procurement is also being worked upon.

The Vice Chair moved to adjourn the meeting and Commissioner Chabot seconded the motion. The Commissioners unanimously voted to adjourn.