COMMISSION MEETING

May 21, 2026

MassGIC

Group Insurance Commission

MA Group Insurance Commission

Public Notice: G.L. C-30A, Sec. 14, May 20, 2026 as amended

Agenda

- **I. Minutes (VOTE)** — 8:30-8:45
  - i. **February 26, 2026**
  - ii. **March 5, 2026**

  Valerie Sullivan, Chair
  Andrew Stern, General Counsel
- **II. Executive Director's Report (INFORM)** — 8:30-8:45

  Matthew Veno, Executive Director
  Members of Senior Staff
- **III. Hospital Price Caps: State Updates and Debunking Common Misconceptions (INFORM)** — 8:45-10:00

  Michael Bailit, MBA
  President, Bailit Health
- **IV. CFO Report (INFORM)** — 10:00 –10:15

  Jennifer Hewitt, Chief Financial Officer
- **V. Other Business/Adjournment** — 10:15-10:30

  Valerie Sullivan, Chair
  Matthew Veno, Executive Director

I

Minutes (VOTE)

Valerie Sullivan, Chair
Andrew Stern, General Counsel

Motion

That the Commission hereby approves the minutes of its meeting held on February 26, 2026 as presented

- Valerie Sullivan, Chair
- Bobbi Kaplan, Vice-Chair
- Anna Freedman (A&F Designee)
- Rebecca Butler (Designee for DOI)
- Martin Curley
- Tamara Davis
- Jane Edmonds
- Gerzino Guirand
- Eileen P. McAnneny
- Kristin Pepin
- Dean Robinson
- Melissa Murphy-Rodrigues
- Jason Silva
- Anna Sinaiko
- Catherine West

Motion

That the Commission hereby approves the minutes of its meeting held on March 5, 2026 as presented

- Valerie Sullivan, Chair
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- Rebecca Butler (Designee for DOI)
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II

Executive Director's Report

Matthew Veno, Executive Director

III

Hospital Price Caps: State Updates and Debunking Common Misconceptions

Michael Bailit, President, Bailit Health

Hospital Price Caps: State Updates and Debunking Common Misconceptions

Group Insurance Commission Meeting

May 21, 2026

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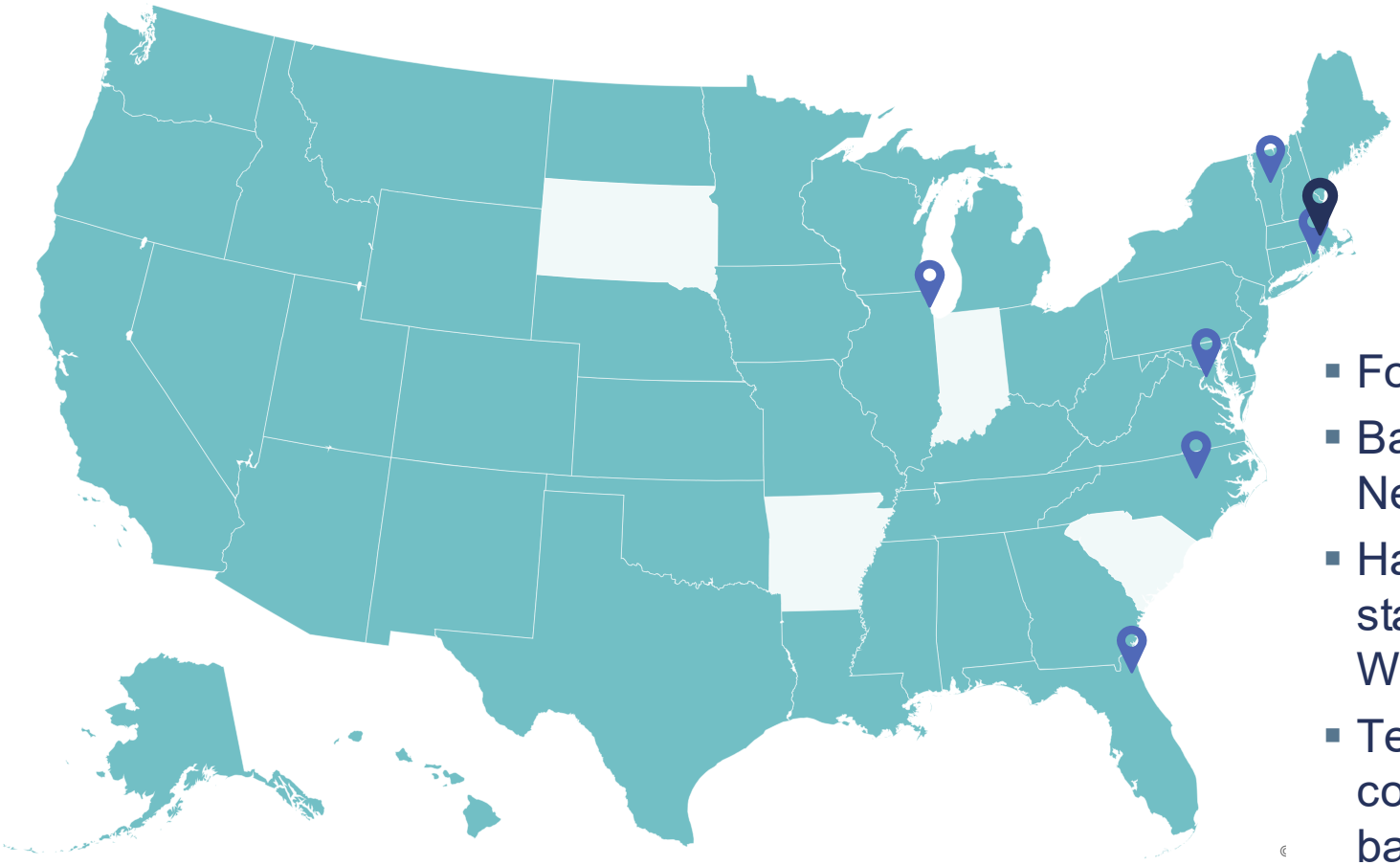
About Bailit Health

Working with state agencies and their partners to improve health care system performance for all.



- Founded in 1997
- Based in Needham
- Have worked in 46 states and Washington, DC
- Team of 14 consultants based in 7 states

Past or current Bailit Health work

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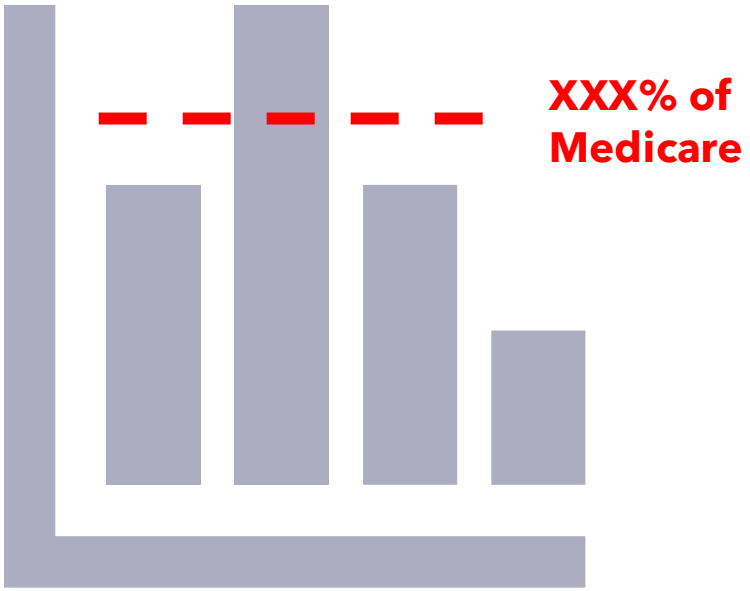
Agenda

- Hospital Price Caps
  - Introduction
  - State Momentum is Growing
  - Debunking Common Misconceptions
  - Why Now?
- Wrap-Up

What are hospital price caps?

- Hospital price caps – also referred to as *payment limits*, *payment caps,* and *reference-based pricing* – limit the payment amounts for hospital services.
  - Limits are established in reference to an external payment benchmark, usually a percentage of Medicare.
  - They typically apply to inpatient and outpatient hospital services, although the scope of services could vary.



State Momentum on Hospital Price Caps

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State interest in capping hospital prices is growing

- To date, **five states** across the political spectrum have implemented or are preparing to implement caps on hospital prices to prevent hospital payments from being unreasonably high.
  - Oregon implemented hospital price caps beginning in 2019.
  - Since 2021, four additional states have passed legislation to implement a hospital price cap.
- During the 2026 legislative session, we've seen other states pursue legislation to advance price caps.

Each state's hospital price cap is unique

- States vary in their hospital price cap design.
- Market application, value of the price cap, and exemptions to the price cap are just a few of the many design options that will impact outcomes.
- Now, I will walk through the hospital price policies of five states.

Oregon

At a Glance	
Program Status	Active
Key Dates	2019 – present
Mechanism	State purchasing authority with legislative directive
Market Subject to Cap	State and school-based employee health plans
Cap Level	**200%** of Medicare for in-network and **185%** for out-of-network
Services Subject to Cap	Hospital inpatient and outpatient services
Exemptions, Alternative Cap Levels	Rural, critical access, and pediatric hospitals are exempted.

Highlights

- **OON Cap:** Oregon included an out-of-network cap (185%) to disincentivize hospitals from leaving insurer networks.
- **Savings:** Cap was estimated to save $113M in 2021 (7% of total spending); 9.5% reduction in out-of-pocket spending per outpatient procedure for individuals in high cost-sharing plans.

New Mexico

At a Glance	
Program Status	Active
Key Dates	July 2025 – present
Mechanism	State purchasing authority with legislative directive
Market Subject to Cap	State and school-based employee health plans
Cap Level	**200%** of Medicare for in-network and **175%** for out-of-network
Services Subject to Cap	Hospital inpatient and outpatient services
Exemptions, Alternative Cap Levels	Applies only to urban hospitals.

Highlights

- **OON Cap:** New Mexico included an out-of-network cap (175%) to disincentivize hospitals from leaving networks.
- **Recent Expansion**: While the initial authorizing legislation was specific to the state benefits program for state/local government employees, the policy was subsequently expanded to apply to public educator health plans (beginning July 2026).
- **Affordability Goals**: Price caps are helping to offset enhanced financial support for state employee coverage.

Vermont

At a Glance	
Program Status	Pre-implementation
Key Dates	Beginning October 2026
Mechanism	Provider regulation
Market Subject to Cap	Entire commercial market
Cap Level	**TBD**
Services Subject to Cap	Hospital inpatient and outpatient services (initially)
Exemptions, Alternative Cap Levels	None specified in statue

Highlights

- **Market:** Vermont's innovative price cap will apply to the entire commercial market (self- and fully insured) via provider-side regulation.
- **Phase-In:** The price cap will begin with inpatient and outpatient services but may include additional services over time.
- **Goal for Consumer Savings:** The State must ensure that savings are passed along to rate payers through lower insurance premiums and to report on this requirement annually.

Washington

At a Glance	
Program Status	Pre-implementation
Key Dates	Beginning 2027
Mechanism	State purchasing authority with legislative directive
Market Subject to Cap	State and school-based employee health plans
Cap Level	**200%** of Medicare for in-network and **185%** for out-of-network
Services Subject to Cap	Hospital inpatient and outpatient services
Exemptions, Alternative Cap Levels	Non-system-owned critical access and sole community hospitals that serve rural areas are exempted. Pediatric hospitals have an alternatively calculated payment limit.

Highlights

- **OON Cap:** Washington includes an out-of-network cap (185%) to disincentivize hospitals from leaving networks.
- **Price Floors:** The price caps are accompanied by price floors of 150% of Medicare rates for primary care and behavioral health services delivered in community settings.
- **Public option price cap**: Washington has also applied aggregate statewide hospital price caps at 160% of Medicare rates in its public option program since 2021.

Indiana

At a Glance	
Program Status	Pre-implementation
Key Dates	Beginning 2029
Mechanism	Provider regulation
Market Subject to Cap	Commercial market
Cap Level	**Aggregate statewide average**
Services Subject to Cap	Hospital inpatient and outpatient services
Exemptions, Alternative Cap Levels	The price cap applies to only to the five largest nonprofit systems in Indiana.

Highlights

- **Market:** Indiana's price cap will apply to the entire commercial market (self- and fully insured) via provider-side regulation.
- **Price Cap:** Indiana's aggregate price cap will be set based on statewide average payment rates for inpatient and outpatient services.
- **Enforcement:** Indiana will leverage a unique lever to enforce the price cap: nonprofit hospitals that fail to meet the cap must forfeit their tax-exempt status until they lower prices below the statewide average.

Hospital Price Caps: Common Misconceptions

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Hospital price caps are often misunderstood

- State efforts to contain excessive hospital prices often unearth common misconceptions.
- States pursuing or preparing to implement price caps may hear myths about hospital price caps, including that they will…
  1. Not address the right problem
  2. Force hospitals to close / impede access to care
  3. Diminish quality of care
  4. Harm the local economy
  5. Lead to cost-shifting
- Together, armed with the evidence base, let's correct each misconception in turn.

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1. Price caps don't address the right problem.

Myth: "Hospital spending growth is due to growth in utilization of services, not price growth."

Evidence-Informed Responses:

- GIC data show that rising health care prices, rather than utilization, have been the **primary driver** of health care spending growth for over a decade.
- This trend is also seen in hospital spending, where rising prices have over time been a much larger contributor to hospital spending growth than increased utilization.

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1. Price caps don't address the right problem.

Myth: "Massachusetts hospital prices are not excessively high, so a price cap is not necessary here."

Evidence-Informed Responses:

- Massachusetts Medicare prices are high, so **Medicare *relative price* isn't a good comparator** for state-level rankings of commercial price levels.
- However, RAND produces **standardized prices** enabling a more apples-to-apples comparison. Prices for a standardized inpatient stay at three Massachusetts hospitals - Brigham & Women's, UMass Memorial Medical Center, and Mass General Brigham - are in the **89th and 90th percentiles for all hospitals nationally**.
- In fact, Massachusetts has some **very high-priced hospital outliers**, with prices for inpatient stays at the most expensive facilities more than double prices for the same services at the least expensive facilities, and prices for lab tests and other routine outpatient services varying as much as 5:1 across hospitals.

1. Price caps don't address the right problem.

Myth: "Hospital prices are high because hospitals are limited in their ability to reduce costs given that so much of their spending goes towards fixed expenses like salaries and facility maintenance."

Evidence-Informed Responses:

- Hospitals are not powerless in determining their expenses; they decide their management structure, staffing levels (including for non-direct patient care labor), and salary levels.
- Extensive evidence shows that **high hospital prices are driven primarily by market power**, rather than by increases in labor and other input costs.
  - Massachusetts hospital prices also vary extensively across hospitals, reflecting market leverage more than underlying costs.
- Evidence further shows that when faced with financial pressures that limit their ability to raise their rates, such as operating in a competitive market, hospitals **manage their operating costs more efficiently**. In addition, studies show that hospitals with higher commercial payments may make the choice to develop a higher cost structure than is necessary.

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See Sources #1 and #2

2. Price caps will force hospitals to close / impede access to care.

Myth: “Capping hospital prices will force hospitals to cut back on services, or possibly even close.”

Evidence-Informed Responses:

- Hospital price cap policy can be informed by **rigorous modeling**, including to understand hospital financial health and the financial impact of capped prices on hospitals.
- The five health systems where the highest proportion of GIC members seek care – MGB, BILH, UMass, Children’s and DFCI – are **all financially stable** according to a holistic assessment of financial health. Those systems have sufficient reserves that could help them withstand price constraints, such as a potential GIC price cap.

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2. Price caps will force hospitals to close / impede access to care.

- The hospital systems visited most by public servants have solid finances – and some are ultra-wealthy.

Health System	Unrestricted funds*
Mass General Brigham	**$13.0 billion**
Beth Israel Lahey Health	**$2.7 billion**
UMass Memorial Health Care	**$1.7 billion**
Boston Children's Hospital	**$6.3 billion**
Dana Farber Cancer Institute	**$1.4 billion**

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SOURCE: Audited financial statements, fiscal years 2019-2024.
* Includes unrestricted cash, investments, and board-designated funds for FY24.

2. Price caps will force hospitals to close / impede access to care.

Myth: “Capping hospital prices will force hospitals to leave health plan networks.”

Evidence-Informed Responses:

- To date, price cap policies in other states **have not resulted in network disruptions**.
- Any threats to leave the GIC’s network based on a potential price cap would be a scare tactic, rather than a decision based on actual projected impact.
- Complementary policies, such as caps on out-of-network rates, can also help to reduce any potential incentive to leave insurer networks.

3. Price caps will diminish quality of care.

Myth: “Hospital price caps will diminish the quality of care.”

Evidence-Informed Responses:

- Hospital price constraints are unlikely to compromise quality of care as there is limited, mixed evidence on whether higher hospital prices are correlated with higher quality of care.
- The association between prices and quality is **affected by many factors** such as hospital size and the health of the hospital’s patients.
- Massachusetts has long documented unwarranted price variation, where hospital prices for the same service vary wildly from one location to another — without correlating with quality.

See Sources #3

4. Price caps will harm the local economy.

Myth: “Capping hospital prices will force hospitals to further eliminate jobs and harm the local economy.”

Evidence-Informed Responses:

- High hospital prices, which are reflected in higher health insurance premiums, harm the local economy as small businesses and municipalities are forced to allocate more and more to health care expenses, which **crowds out wages** and **stifles growth and hiring**.
- In addition, we know from hospital case examples and the literature that when faced with financial/revenue pressures, **hospitals can take steps to manage their administrative and clinical costs more efficiently** to reduce overall costs, rather than defaulting to job cuts.

See Sources #4

5. Price caps will lead to cost-shifting.

Myth #1: “Hospitals have to maintain higher commercial prices because Medicare and Medicaid don’t pay enough, forcing hospitals to engage in ‘cost-shifting.’”

Evidence-Informed Responses:

- Extensive research shows that hospitals do not raise prices in response to lower Medicare and Medicaid payment levels, but rather to **maximize revenue**.
- In addition, well-resourced hospitals have choices regarding how to spend their money. When large hospital systems are spending money on expansions, the GIC and other commercial plans should not be subsidizing those costs.

See Sources #5

5. Price caps will lead to cost-shifting.

Myth #2: “The proposed price cap will result in hospitals increasing prices for services or for health plans not covered by the price cap.”

Evidence-Informed Responses:

- Since Oregon first implemented a price caps program for their state and school-based employee health plans in 2019, they have **not seen prices for other insurance plans or services go up**.
- While hospitals could use the price cap as justification to try to increase their prices for non-capped services and plans, those with the most GIC revenue are financially healthy. Hospitals can instead take measures to manage their operating costs more efficiently, rather than cost-shifting.

Why should the GIC consider price caps now?

- Following the passage of HR 1, it is more important than ever to slow commercial market spending growth. With HR 1 cutting federal funding to the state, there is simply not enough money to pay for excessively high hospital prices.

- We shouldn't be looking to state employees and Massachusetts taxpayers to recoup lost revenue from HR 1, especially with recent double-digit premium increases that will further eat into the state budget and strain household budgets.

Questions?

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IV

CFO Report

Jennifer Hewitt, GIC Chief Financial Officer

FY2026 Spending Year-to-Date – State Share Premium Accounts

($ millions)	July '25	August	Sept.	Oct.	Nov.	Dec.	Jan.'26	Feb.	Mar.	April	Total**
Pharmacy Claims (CVS/SilverScript)	$144.2*	$86.8	$42.3	$118.8	$67.2	$9.4	$79.4	$87.0	$1.0	$73.1	$709.1
Health New England Claims	$10.5	$9.2	$10.8	$8.6	$9.8	$10.5	$8.0	$10.3	$15.2	$9.5	$102.4
Mass General Brigham Claims	$15.3	$10.9	$10.0	$13.9	$12.4	$13.1	$10.6	$11.5	$13.5	$16.5	$127.7
Point32 Claims	$115.0*	$67.5	$85.1	$71.6	$67.6	$74.1	$64.0	$71.6	$89.6	$79.5	$785.7
Wellpoint Claims	$122.5*	$65.4	$70.9	$72.0	$68.2	$85.9	$96.4	$83.7	$79.2	$95.6	$840.0
Claims Subtotal**	$407.5*	$239.9	$219.2	$284.9	$225.1	$193.1	$258.4	$264.1	$198.4	$274.1	$2,564.9
Basic/RMT Life Ins. Premiums	$1.7	$1.7	$1.7	$1.7	$1.7	$1.7	$1.7	$1.7	$1.7	$1.7	$17.1
Tufts Medicare Preferred	$0.7	$0.7	$0.7	$0.7	$0.7	$0.7	$0.7	$0.6	$0.7	$0.7	$6.7
UBH Optum EAP	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.1	$0.8
ASO Administrative Fees	$10.2	$8.8	$8.8	$8.7	$8.7	$8.9	$8.7	$8.7	$8.7	$8.8	$88.8
Other Costs	$0.2	$1.4	$0.3	$0.3	$0.4	$0.2	$0.2	$0.3	$0.2	$0.2	$3.9
Dental/Vision Expenses	$1.0	$1.0	$1.0	$1.0	$1.0	$1.0	$1.0	$1.0	$1.0	$1.1	$10.2
Other Expenses Subtotal**	$13.9	$13.7	$12.6	$12.5	$12.5	$12.6	$12.3	$12.4	$12.4	$12.5	$127.5
Combined Total**	$421.4*	$253.6	$231.7	$297.5	$237.7	$205.7	$270.7	$276.5	$210.8	$286.7	$2,692.4

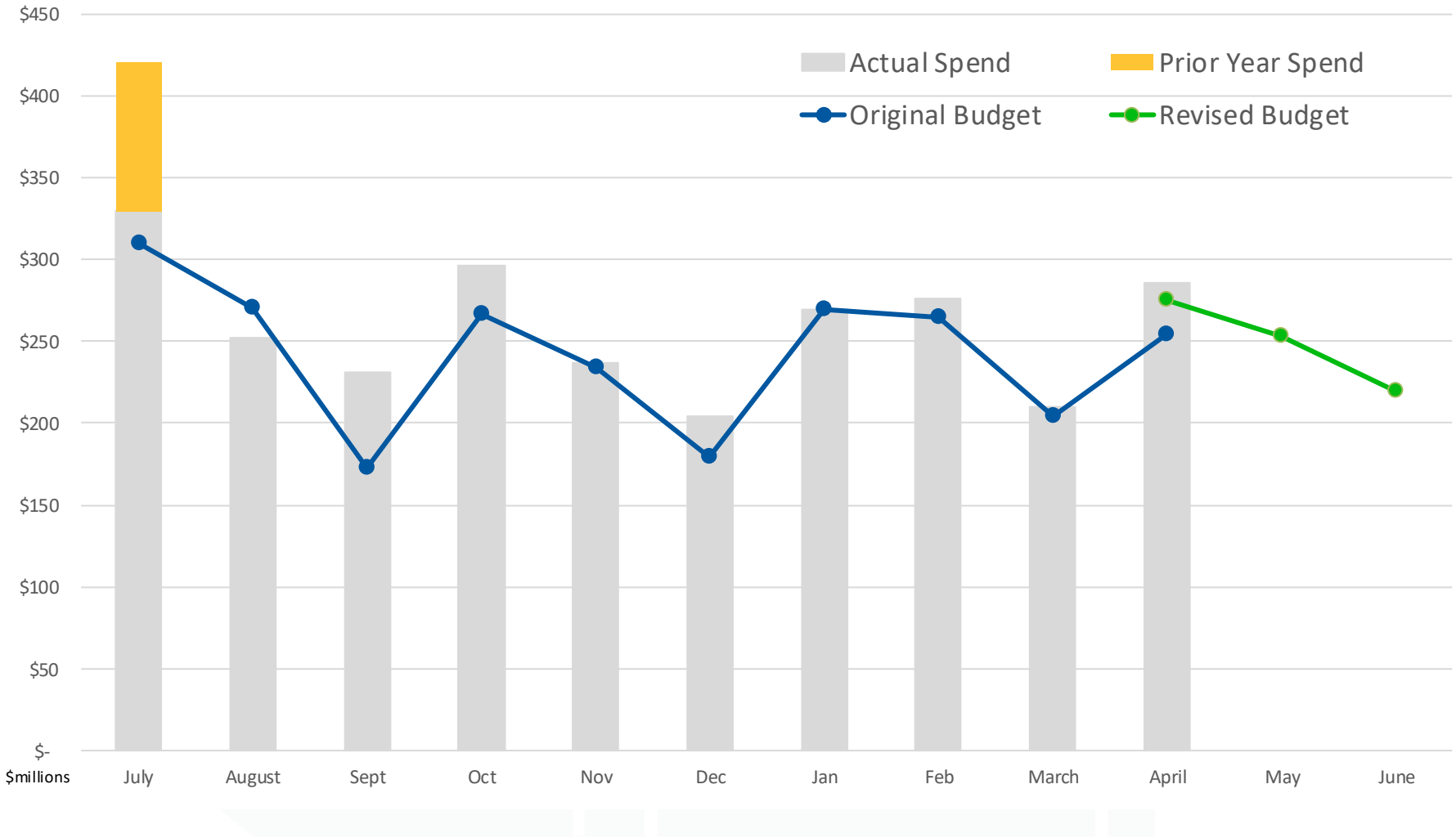
*Restated some July 2025 values to capture corrected allocation between State and Enrollee accounts.
**Totals may not add due to rounding.

FY2026 Spending Year-to-Date – Enrollee Share Premium Accounts

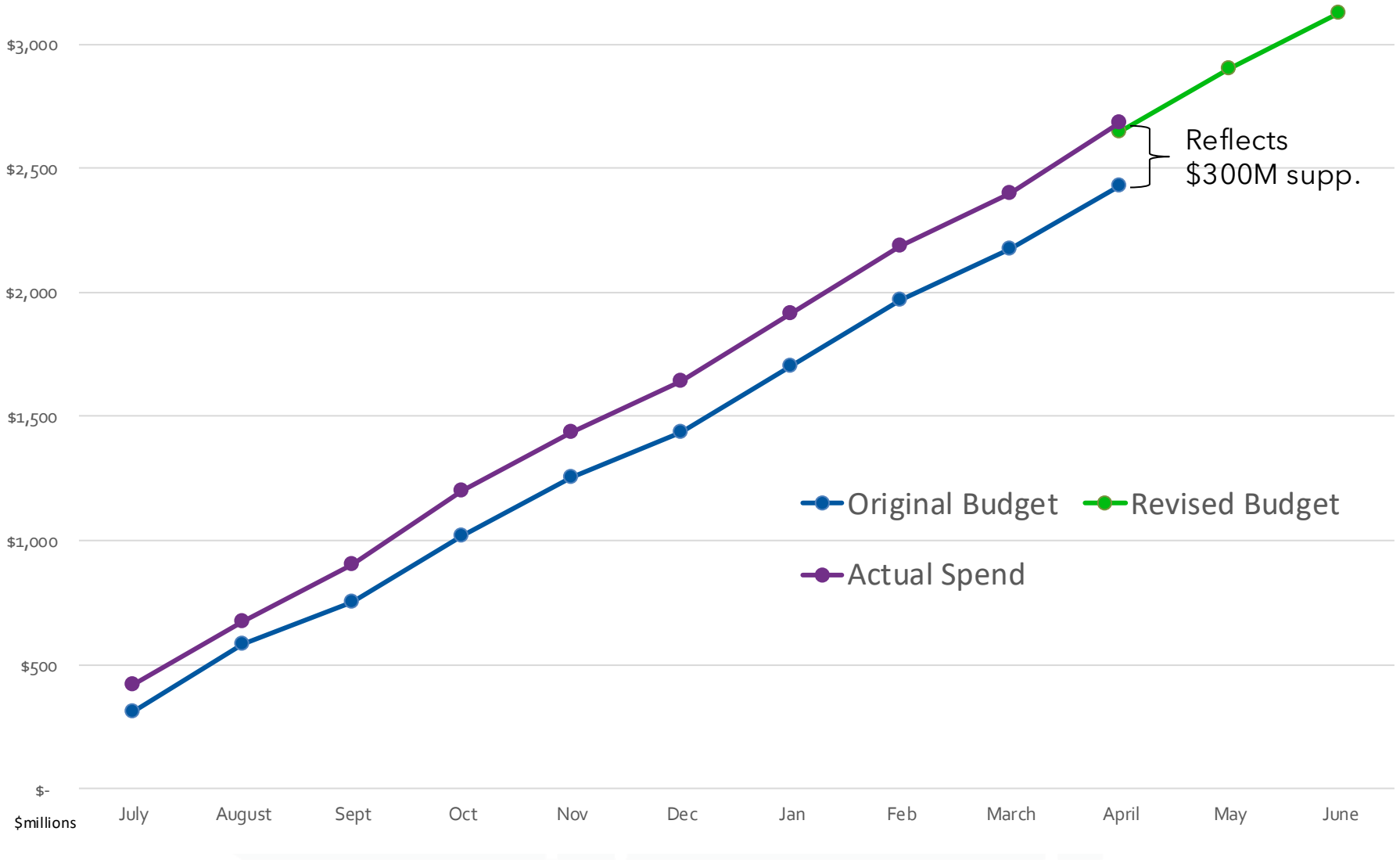
($ millions)	July '25	August	Sept.	Oct.	Nov.	Dec.	Jan.'26	Feb.	Mar.	April	Total**
Pharmacy Claims (CVS/SilverScript)	$11.7*	$23.3	$11.0	$32.5	$19.1	$3.0	$23.3	$24.1	$0.2	$21.0	$169.2
Health New England Claims	$3.2	$2.8	$2.6	$3.4	$3.6	$2.5	$1.8	$3.7	$4.6	$2.2	$30.5
Mass General Brigham Claims	$4.8	$3.4	$3.1	$4.3	$3.9	$4.1	$3.3	$4.4	$5.3	$4.0	$40.5
Point32 Claims	$8.4*	$19.5	$24.7	$20.8	$19.6	$21.5	$18.6	$28.5	$25.9	$23.1	$210.6
Wellpoint Claims	$8.0*	$18.4	$20.0	$20.2	$19.1	$24.3	$27.2	$23.4	$22.3	$27.1	$210.1
Claims Subtotal**	$36.0*	$67.5	$61.4	$81.1	$65.4	$55.4	$74.2	$84.1	$58.4	$77.3	$660.9
Basic/Voluntary Life Ins. Premiums	$5.1	$5.1	$5.2	$5.2	$5.2	$5.2	$5.2	$5.2	$5.3	$5.1	$51.9
Long-Term Disability Ins. Premiums	$1.3	$1.3	$1.3	$1.4	$1.4	$1.4	$1.4	$1.4	$1.4	$1.4	$13.6
Tufts Medicare Preferred	$0.2	$0.2	$0.2	$0.1	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$1.6
UBH Optum EAP	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.2
ASO Administrative Fees	$2.1	$2.4	$2.4	$2.4	$2.4	$2.3	$2.4	$2.4	$2.4	$2.5	$23.8
Dental/Vision Expenses	$2.4	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$24.8
Other Expenses Subtotal**	$11.2	$11.5	$11.6	$11.6	$11.7	$11.5	$11.7	$11.7	$11.8	$11.6	$115.8
Combined Total**	$47.2*	$79.0	$73.1	$92.8	$77.0	$66.9	$85.9	$95.7	$70.1	$88.9	$776.7

*Restated some July 2025 values to capture corrected allocation between State and Enrollee accounts.
**Totals may not add due to rounding.

GIC State Appropriation for Health Premium Account
FY2026 Available Funds vs. Actual Spending
as of April 30, 2026



GIC State Appropriation for Health Premium Account
FY2026 Available Funds vs. Actual Spending - Cumulative



FY2026 GIC Summary Budget

Health Benefits	GAA	Supplemental	Total Available	Spent thru 4/30
1108-5200 – Actives	$2,372,061,737	$300,000,000	$2,672,061,737	$2,232,194,828
1599-6152 – Retirees*	$450,000,000	$ -	$450,000,000	$450,000,000
Total Health Budget	$2,822,061,737	$300,000,000	$3,122,061,737	$2,682,194,828

Dental/Vision Benefits	$12,634,259	$ -	$12,634,259	$ 10,244,955
Combined Benefits	$2,834,695,996	$300,000,000	$3,134,695,996	$2,692,439,783

*$100M of the $300M supplemental was due to a reduction in available funding to the State Retiree Benefit Trust Fund (SRBTF) for retiree health costs. The SRBTF had been traditionally funded at $550M.

FY2027 GIC Summary Budget

Health Benefits	H.2, House/Senate	Projected Spending Need	Projected Shortfall
1108-5200 – Actives	$2,765,209,719	$2,815,709,719	$52,500,000
1599-6152 – Retirees*	$400,000,000	$550,000,000	$150,000,000
Total Health Budget	$3,165,209,719	$3,367,709,719	$202,500,000

Dental/Vision Benefits	$12,634,259	$12,634,259	$ -
Combined Benefits	$3,177,843,978	$3,380,343,978	$202,500,000

*Health spending for Retirees was broken into an Operating Transfer to the State Retiree Benefit Trust Fund (SRBTF) in the late 2000s. The pending FY2027 budgets anticipate dedicating up to $150M in Excess Capital Gains in FY2027 to the SRBTF, in lieu of direct funding via the budget. Those amounts are not known nor available until May or June, which makes it difficult to pay health claims and creates a shortfall.

V

Other Business and Adjournment

Valerie Sullivan, Chair
Matthew Veno, Executive Director

Appendix: Sources

Sources #1

- Evidence shows that high hospital prices are driven primarily by market power, rather than by increases in labor and other input costs.
  - Li S, Jones D, Rich E, Landsale A. How do hospitals exert market power? Evidence from health systems and commercial health plan prices. *Health Affairs Scholar.* 2025;3(1). https://academic.oup.com/healthaffairsscholar/article/3/1/qxae179/7958335
  - Jenkins D, Tapaneeyakul S, Ho V. Prices Versus Costs: Unpacking Rising US Hospital Profits. Rice University's Baker Institute for Public Policy. September 2024. https://www.bakerinstitute.org/research/prices-versus-costs-unpacking-rising-us-hospital-profits#_edn1
  - Medicare Payment Advisory Commission Report to Congress. March 2025 (pages 55-56, 86). https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf
  - Cooper Z, Craig SV, Gaynor M, Van Reenen J, The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, *The Quarterly Journal of Economics*, Volume 134, Issue 1, February 2019. https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext&login=false

Sources #2

- Evidence shows that when faced with financial pressures that limit their ability to raise their rates, such as operating in a competitive market, hospitals can manage their operating and clinical costs more efficiently.
  - Lee VS, Kawamoto K, Hess R, et al. Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes and Association With Reduced Cost and Improved Quality. *JAMA.* 2016;316(10). https://jamanetwork.com/journals/jama/fullarticle/2552208
  - Pronovost P. Living and Leading with Love: Transforming Healthcare through Mutual Respect and Accountability. Innovations: Technology, Governance, Globalization 2025; 14 (1-2): 32–54. https://direct.mit.edu/itgg/article/14/1-2/32/134016/Living-and-Leading-with-Love-Transforming
  - Virgina Mason Production System Overview and Success Stories. https://www.vmfh.org/about-vmfh/research-care-quality/virginia-mason-production-system, https://www.vmfh.org/about-vmfh/research-care-quality/virginia-mason-production-system/vmps-success-stories
  - Owens C. 1 big thing: Into the hospital margin rabbit hole. Axios Future of Health Care Newsletter. August 2024. https://www.axios.com/newsletters/axios-future-of-health-care-38c6afb0-657c-11ef-b7cd-4f350631fbdf.html?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosfutureofhealthcare&stream=top
  - Medicare Payment Advisory Commission Report to Congress. March 2025 (pages 55-56, 86). https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf

Sources #3

- The evidence on whether higher hospital prices are correlated with higher quality of care is mixed.
  - Crespin DJ and Whaley C. The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality. *Health Services Research.* July 2022, 58(1):91-100. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14040
  - Cooper Z, Doyle Jr JJ, Graves KA, Gruber J. Do Higher-Priced Hospitals Deliver Higher-Quality Care? *National Bureau of Economic Research*. NBER Working Paper Series. February 2022, Revised January 2023. https://www.nber.org/system/files/working_papers/w29809/w29809.pdf
  - Beauvais B, Gilson G, Schwab S, Jaccaud B, Pearce T, Holmes T. Overpriced? Are Hospital Prices Associated with the Quality of Care? *Healthcare (Basel).* May 2020, 8(2):135. https://pubmed.ncbi.nlm.nih.gov/32429552/
  - Baum A, Song S, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs.* February 2019, 38(2): 237–245. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

Sources #4

- High hospital prices, which are reflected in higher health care insurance premiums, harm the local economy as small businesses and municipalities are forced to allocate more and more to health care expenses, which crowds out wages and stifles growth and hiring.

  - Vaznis J. Health insurance costs are rising sharply, and Mass. towns and schools districts face a budget nightmare. *The Boston Globe*. January 5, 2026. https://www.bostonglobe.com/2026/01/05/metro/health-insurance-costs-school-districts-municipalities/?p1=Article_Inline_Text_Link
  - Brot-Goldberg Z, Cooper Z, et al. Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers. *National Bureau of Economic Research*. Working Paper. June 2024. https://www.nber.org/papers/w32613
  - Kanimian S, Ho V. Why does the cost of employer-sponsored coverage keep rising? *Health Affairs Scholar*. June 2024, 2(6). https://academic.oup.com/healthaffairsscholar/article/2/6/qxae078/7687295
  - Hager K, Emanuel E, Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families. *JAMA Network Open*. January 2024, 7(1). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927
  - Arnold D, Whaley CM. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. RAND Corporation. July 2020. https://www.rand.org/pubs/working_papers/WRA621-2.html
  - 2025 National Alliance of Healthcare Purchaser Coalition survey. https://www.nationalalliancehealth.org/wp-content/uploads/Pulse-of-the-Purchaser-2025-Annual-Survey.pdf
  - 2025 Small Business for America's Future survey. https://irp.cdn-website.com/b4559992/files/uploaded/SBAF_Healthcare_Costs_Survey_APRIL_2025.pdf

Sources #5

- Research shows that hospitals do not raise prices in response to lower Medicare and Medicaid payment levels, but rather to maximize revenue.
  - Blavin F, Kane N, Berenson R, Blanchfield B, Zuckerman S. Association of Commercial-to-Medicare Relative Prices With Health System Financial Performance. *JAMA Health Forum*. February 2023, 4(2). https://doi.org/10.1001/jamahealthforum.2022.5444
  - Congressional Budget Office. The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. January 2022, 26-28. https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf
  - Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy, Chapter 15: Congressional request on health care provider consolidation. March 2020, 468-469, 497-499 (Appendix 15-A). https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_medpac_ch15_sec-pdf/

Appendix: Hospital Financials

bailit health

Financial Health of Five Systems Serving Highest Numbers of GIC Members

Mass General Brigham (MGB) • One of the wealthiest health systems in the state. • Moderate margins but very strong cash position to help it through tough times. • Can easily cover its debt.	**$13.0** **billion** in unrestricted funds in 2024*
Beth Israel Lahey Health (BILH) • Solid finances overall. • Despite lower-than-usual margin, has healthy cash on hand. • High credit rating and manageable debt load.	**$2.7** **billion** in unrestricted funds in 2024*
UMass Memorial Health Care (UMMHC) • Stable finances. • Losses in FY19-23 but a strong year in FY24. • Sufficient cash and ability to cover its debt. • Investing in facility and equipment improvements. • Could be vulnerable if it experiences major future losses.	**$1.7** **billion** in unrestricted funds in 2024*
Boston Children's Hospital (BCH) • Very wealthy and resilient health system. • Very profitable when investment income is included. • Manageable debt and high credit ratings. • Could operate for two years without additional income.	**$6.3** **billion** in unrestricted funds in 2024*
Dana Farber Cancer Institute (DFCI) • Strong financial position. • Consistently profitable, supported by earnings from patient care and high donations. • Sufficient cash, manageable debt. • Unrestricted reserves have doubled since 2019 – and it has another $1.8 billion in restricted funds.	**$1.4** **billion** in unrestricted funds in 2024*

bailit health

SOURCE: Audited financial statements, fiscal years 2019-2024.
* Includes unrestricted cash, investments, and board-designated funds.

2026 Group Insurance Commission Meetings & Schedule

January	February	February	March	May
15	12	26	5	21

June	September	October	November	December
18	17	15	19	17

Unless otherwise announced in the public notice, all meetings take place from 8:30 am - 10:30 am on the 3rd Thursday of the month. Meeting notices and materials including the agenda and presentation are available at **mass.gov/gic** under Upcoming Events prior to the meeting and under Recent Events after the meeting.

Please note:

- Until further notice, Commissioners will attend meetings remotely via a video-conferencing platform provided by GIC.
- Anyone with Internet access can view the livestream via the MA Group Insurance Commission channel on YouTube. The meeting is recorded, so it can be replayed at any time.

Note: Topics and meeting dates are subject to change

Appendix

Commission Members

GIC Leadership Team

GIC Goals

GIC Contact Channels

Commission Members


Valerie Sullivan, Public Member, Chair


Bobbi Kaplan, NAGE, Vice-Chair


Michael Caljouw, Commissioner of Insurance


Matthew Gorzkowicz, Secretary of Administration & Finance

Martin Curley, Public Member

Kristin Pepin, NAGE


Tamara P. Davis, Public Member

Dean Robinson, Massachusetts Teachers Association


Jane Edmonds, Retiree Member


Melissa Murphy-Rodrigues, Mass Municipal Association

Gerzino Guirand, Council 93, AFSCME, AFL-CIO

Jason Silva, Mass Municipal Association


Eileen P. McAnneny, Public Member


Anna Sinaiko, Health Economist


Catherine West, Public Member

GIC Leadership Team

Matthew A. Veno, Executive Director

Erika Scibelli, Deputy Executive Director

Emily Williams, Chief of Staff

Jennifer Hewitt, Chief Fiscal Officer

Paul Murphy, Director of Operations

Andrew Stern, General Counsel

Stephanie Sutliff , Chief Information Officer

John Viarella, Director of Human Resources

GIC Goals

1. Provide access to high quality, affordable benefit options for employees, retirees and dependents
2. Limit the financial liability to the state and others (of fulfilling benefit obligations) to sustainable growth rates
3. Use the GIC's leverage to innovate and otherwise favorably influence the Massachusetts healthcare market
4. Evolve business and operational environment of the GIC to better meet business demands and security standards

Contact GIC for Enrollment and Eligibility

- Enrollment
- Retirement
- Premium Payments
- Qualifying Events
- Life Insurance
- Long-Term Disability
- Information Changes
- Marriage Status Changes
- Other Questions

Online Contact	mass.gov/forms/contact-the-gic	Any time. Specify your preferred method of response from GIC (email, phone, mail)
Email	gicpublicinfo@mass.gov	
Telephone	(617) 727-2310, M-F from 8:45 AM to 5:00 PM	
Office location	1 Ashburton Place, Suite 1413, Boston, MA, Not open for walk-in service	
Correspondence & Paper Forms	P.O. Box 556 Randolph, MA 02368	Allow for processing time. Priority given to requests to retain or access benefits

Contact Your Health Carrier for Product and Coverage Questions

- Finding a Provider
- Accessing tiered doctor and hospital lists
- Determining which programs are available, like telehealth or fitness
- Understanding coverage

Health Insurance Carrier	Telephone	Website
Mass General Brigham Health Plan	(866) 567-9175	massgeneralbrighamhealthplan.com/gic-members
Harvard Pilgrim Health Care	(844) 442-7324	point32health.org/gic
Health New England	(800) 842-4464	hne.com/gic
Tufts Health Plan (Medicare Only)	(855) 852-1016	Tuftshealthplan.com/gic
Wellpoint Non-Medicare Plans Medicare Plans	 (833) 663-4176 (800) 442-9300	wellpoint.com/mass