COMMISSION MEETING

December 18, 2025

MassGIC

Group Insurance Commission

MA Group Insurance Commission

Public Notice: G.L. C-30A, Sec. 14, December 16, 2025

Agenda

I. Minutes, November 20, 2025 (VOTE) Valerie Sullivan, Chair Andrew Stern, General Counsel	8:30-8:35
II. Executive Director's Report (INFORM) Matthew Veno, Executive Director Members of Senior Staff	8:35-8:45
III. FY2027 Preliminary Cost Increase (INFORM) Brian Stitzel, Senior Director, Health & Benefits, WTW	8:45 –9:15
IV. Continued Discussion about Balancing Benefits with the Budget (INFORM) Matthew Veno, Executive Director Margaret Anshutz, Director of Health Policy and Analytics	9:15–10:00
V. CFO Report (INFORM) Jennifer Hewitt, Chief Financial Officer	10:00-10:20
VI. Other Business/Adjournment Valerie Sullivan, Chair Matthew Veno, Executive Director	10:20-10:30

I

Approval of Minutes (VOTE)

Valerie Sullivan, Chair
Andrew Stern, General Counsel

Motion

That the Commission hereby approves the minutes of its meeting held on November 20, 2025 as presented

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

II

Executive Director's Report

Matthew Veno, Executive Director
Members of the Senior Staff

2026 Public Information Sessions

Register* today at Mass.gov/GIC

JANUARY	JANUARY	JANUARY
27	27	29
12:00 PM	6:00 PM	9:00 AM

*Please register for only one session. All sessions contain the same information.

III

FY2027 Preliminary Cost Increase

Brian Stitzel, Senior Director, Health and Benefits, WTW

Expected FY27 Budget Increase – Context Setting

Why are we here today?

- Based on the current medical and pharmacy carriers and plan design offerings, preliminary Fiscal Year 2027 (FY27) full cost premiums were developed for each of the GIC's products (Non-Medicare and Medicare)
- The purpose of this discussion is to present FY27 Medical and Pharmacy preliminary pricing projections prior to incorporating strategic plan design changes
- A premium reflects the total sum of money that the product is expected to cost in claims and fees (for medical and pharmacy), including the Commonwealth, municipalities and member portion; typically displayed as a monthly amount

What are premiums?

- Out-of-pocket costs at point of service are not included in premiums (e.g., office visit copays)
- Premiums reflect the full cost – members only pay a portion of the full cost premium

How were the premiums developed?

- Self-insured (i.e., ASO): WTW actuaries calculate FY27 premiums utilizing claims data, member data, and trend assumptions developed by the carriers; the individual and family premiums reflect the claims experience and demographics for each product offered (applies to Non-Medicare and Medicare Supplement plans for the GIC)
- Fully-insured: Rates are developed by the carriers, and negotiated by the GIC/WTW for FY27 (applies to Medicare Advantage medical portion only)

Expected FY27 Budget Increase – Context Setting

Healthcare cost increases are at the highest point in over a decade

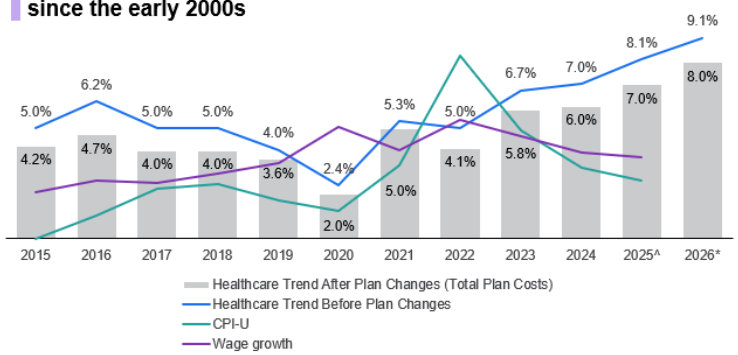
More than half of organizations were over budget by an average of 4.5 percentage points

73% of organizations are feeling more cost pressure today than at any point in the past 10 years

51% of organizations' healthcare costs exceeded budgets in 2024 — 31% met budget

4.5 percentage points
Average amount that organizations exceeded their original budgets

Healthcare cost trends approach levels not seen since the early 2000s



Top drivers of healthcare costs

#1	**Pharmacy cost, primarily specialty pharmaceuticals and GLP-1 medications**
#2	**High-cost claimants**
#3	**Chronic conditions, particularly musculoskeletal, cancer and oncology**
#4	Inflation
#5	Gene and cell therapies
#6	Utilization increases
#7	Mental health and behavioral services
#8	Demographic factors
#9	Maternity and fertility

Expected FY27 Budget Increase – Context Setting

General Inflation

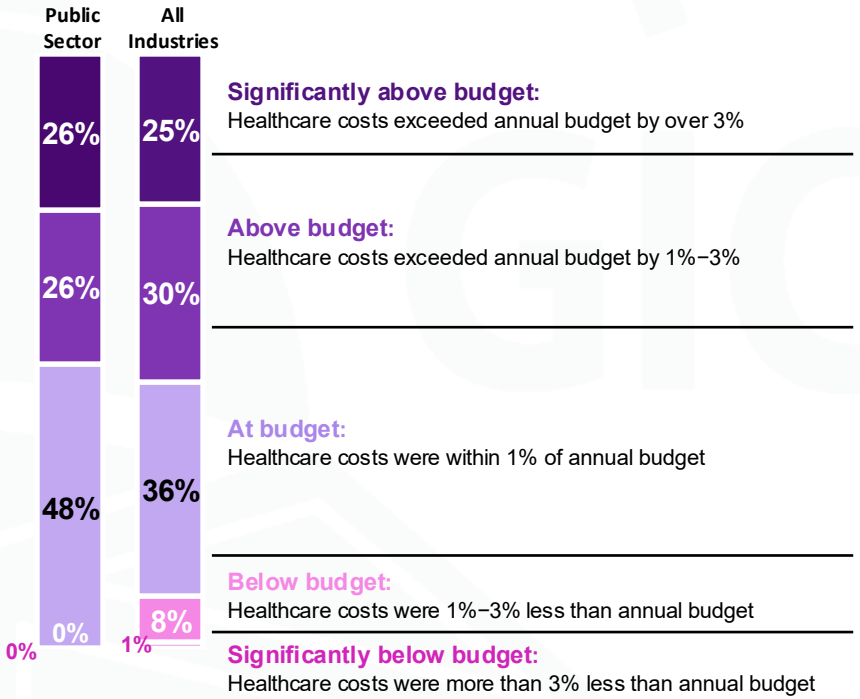
While recent reports indicate inflation rates are somewhat stabilizing, CPI is still higher than historical rates

Incremental Health Care Inflation

Healthcare trend continues to outpace CPI, driven by contentious contract renegotiations between carriers and providers, industry consolidation, and continued clinical labor shortages,
among other factors

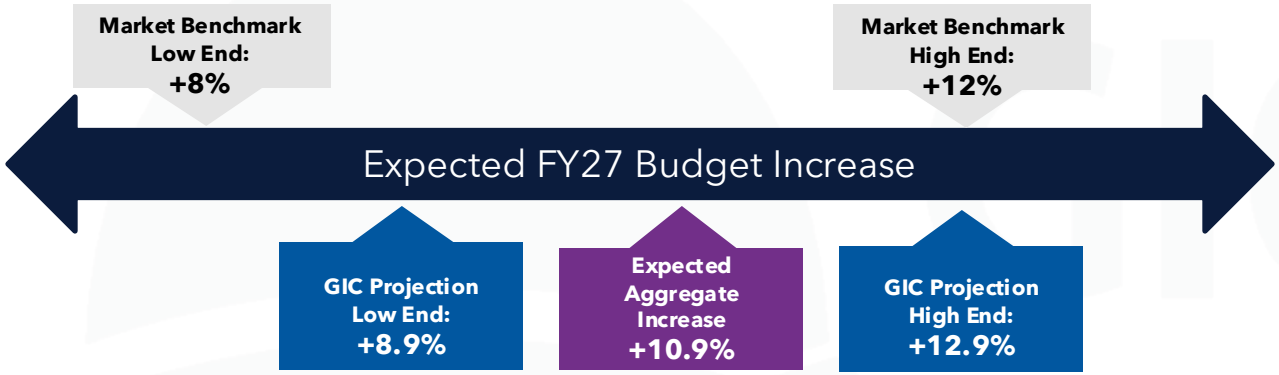
Expectations on organizations' healthcare costs for 2025

Source: WTW 2025 Best Practices in Healthcare Survey



Preliminary FY27 Budget Increase

- "Preliminary" = Current plan options, programs, plan design, funding mechanism; no anticipated migration or material changes in member behavior
- The preliminary projection does include estimated impact from Vida on GLP-1 spend



Next Steps:

- Finalize pricing assumptions
- Evaluate and vote on plan design changes, including cost impacts
- Adjust the budget rates increase accordingly and develop premium rates by plan

IV

Continued Discussion: Balancing Benefits with the Budget

Matthew Veno, Executive Director
Margaret Anshutz, Director of Health Policy and Analytics

Discussion

- What principles would you like to see staff follow and prioritize when considering potential budget saving measures?

- Are there any additional strategies, beyond those listed, that the Commission would like to see the staff evaluate for consideration?

Options for Benefit Design Changes

Legend

- Not applicable
- Some misalignment with GIC priorities
- Strongly misaligned with GIC priorities
- Aligned with GIC priorities

Initiative	Estimated Annual Savings	Alignment with GIC Strategic Priorities: Member Affordability	Behavioral Health	Health Equity
Plan Design Changes				
Increase urgent care copay $20 to $30*	$	Some misalignment	Not applicable	Not applicable
Remove three free mental health visits (telehealth)	$	Some misalignment	Strongly misaligned	Not applicable
Increase ER copay from $100 to $150*	$	Some misalignment	Not applicable	Not applicable
Limit coverage for hearing aids to only what is mandated in MA: ▪ Reduce coverage for those <21 from every 24 months to every 36 months ▪ Remove coverage for 22+ age group	$	Some misalignment	Not applicable	Strongly misaligned

*While these changes represent a cost shift to members, it's important to consider that the GIC's urgent care and ER copays are currently below market. Raising copays for any service could impact timely access to needed care for members with lower incomes. Lower utilization could lead to additional cost savings.

Options for Benefit Design Changes

Legend

- Not applicable
- Some misalignment with GIC priorities
- Strongly misaligned with GIC priorities
- Aligned with GIC priorities

Initiative	Estimated Annual Savings	Alignment to GIC Strategic Principles: Member Affordability	Behavioral Health	Health Equity
Plan Design Changes				
Increase out of network coinsurance for plans that cover out-of-network services	$$	Strongly misaligned	Strongly misaligned	Not applicable
Implement a uniform methodology for health carrier reimbursement to out-of-network providers in Massachusetts*	$$$	Aligned	Not applicable	Not applicable
Increase office visit copays: PCP: $10/$20/$40 → $15/$30/$60 Specialist: $30/$60/$75 → $35/$70/$90	$$$	Some misalignment	Not applicable	Not applicable

* If accompanied by member protection legislative language, an OON reimbursement cap would encourage providers to stay in-network and improve member accessibility/affordability. Without this legislative language, members may be turned away from OON providers.

Options for Benefit Design Changes

Legend

- Not applicable
- Some misalignment with GIC priorities
- Strongly misaligned with GIC priorities
- Aligned with GIC priorities

Initiative	Estimated Annual Savings	Alignment with GIC Strategic Priorities: Member Affordability	Behavioral Health	Health Equity
Deductible Increases – Commercial Plans*				
Increase Medical deductible by $100/$200 (individual/family) National/Broad networks: $500/$1,000 → $600/$1,200 Limited networks: $400 → $500	$$$			
Increase Medical deductible by $250/$500 (individual/family) National/broad networks: $500/$1,000 → $750/$1,500 Limited networks: $400 → $650	$$$$			

*Higher deductibles impact member affordability. Research shows higher deductible leads to decreased utilization of needed care, which is especially impactful to lower income members The deductible does not apply for behavioral health services.

Options for Benefit Design Changes

Legend

- Not applicable
- Some misalignment with GIC priorities
- Strongly misaligned with GIC priorities
- Aligned with GIC priorities

Initiative	Estimated Annual Savings	Alignment with GIC Strategic Priorities: Member Affordability	Behavioral Health	Health Equity
Pharmacy				
Copay assistance card program (Prudent Rx)*	$$$$	Strongly misaligned / Aligned	Not applicable	Not applicable
Obesity Management: Remove GLP-1 coverage	$$$$$	Strongly misaligned	Not applicable	Strongly misaligned
Dental Contribution Ratio				
Increase member contribution rate from 15% to 25%, aligning it to the predominant premium split that exists for medical coverage	$	Strongly misaligned	Not applicable	Not applicable
Surviving Spouse Contribution Ratio				
Increase contribution rate of surviving spouses from 10% to match the decedent's contribution ratio (10%, 15%, 20% or 25%)	$$	Strongly misaligned	Not applicable	Not applicable

*Impact on member affordability will depend on member participation. Members who enroll in the Prudent Rx solution have lower OOP costs, but members pay higher coinsurance if they do not participate. Robust communications and outreach are key to program engagement.

Lessons From Other States on Managing Health Care Cost Drivers

State legislative, regulatory, and administrative action to address market prices

Provider price caps

- High unit prices are largely responsible for high US medical costs
- In many states, average hospital rates exceed 250% of Medicare rates
- Some states have attempted to address this through Medicare referenced-based price caps, which can apply to state employees only or to all payers

Source: Millbank Memorial Fund: How States Strengthened Their Health Care Markets in the 2025 Legislative Session (August 2025)

State spotlight: pathways to price caps

State	Who and how much?	How?
Washington (2025)	State employees and teachers and state exchange capped at 200%	Legislative
Oregon (2017)	State employees and teachers capped at 200% Medicare	Legislative
Vermont (2025)	Commercial market	Legislative
Indiana (2025)	1. Largest non-profit health system's aggregate IP/OP under state average by 2029; 2. Largest non-profit hospitals capped IP/OP at 260% with direct-to-employer contracts	Legislative
Montana (2016-2022)	Public employee health plan capped at 220-250% IP; 230-250% OP	Legislative
North Carolina (2020-2025)	Price caps administered through health plan-provider negotiations	Administrative
New Mexico (2025)	State employee health plan capped at 200%	Legislative

Massachusetts market considerations

Lessons learned from other states

- **Implementation of provider price caps was most successful with legislation**
  - NC advanced price caps administratively and providers opted out
  - Legislation requires significant stakeholder work, engagement with partners in government and industry

Hospital financial landscape

- **Haves and have-nots**
  - Systems with the highest commercial reimbursement rates are strong financially, based on our evaluations
  - Independent community hospitals are struggling financially, but also have lower commercial reimbursement rates

- **Hospital finance is more than the bottom line or operating margin**
  - Just because a hospital is losing money, doesn't mean that they are underpaid
  - Hospitals are investing in expensive equipment and expansions while threatening lay-offs
  - Heath policy literature shows that hospitals reduce costs when faced with revenue challenges
  - Federal cuts for Medicaid and enhanced subsidies

Policy work for the GIC in 2026

- Model what Medicare reference-based pricing looks like at various thresholds and what percentage of systems' revenue GIC accounts for
- Evaluate what price caps in MA would mean for the GIC, state budget, and hospital systems

V

CFO REPORT

Jennifer Hewitt, Chief Financial Officer

FY2026 Known Fiscal Challenges

	($ millions)
Previously Discussed Items	$ 77.0
Mid-year Administrative Changes	$ (20.0)

Newly Recognized Items

State Retiree Benefit Trust Fund (SRBTF)	$ 42.0
FY2025 Enrollee Account Deficit	$ 54.0

Total Initial Funding Shortfall	$ 153.0

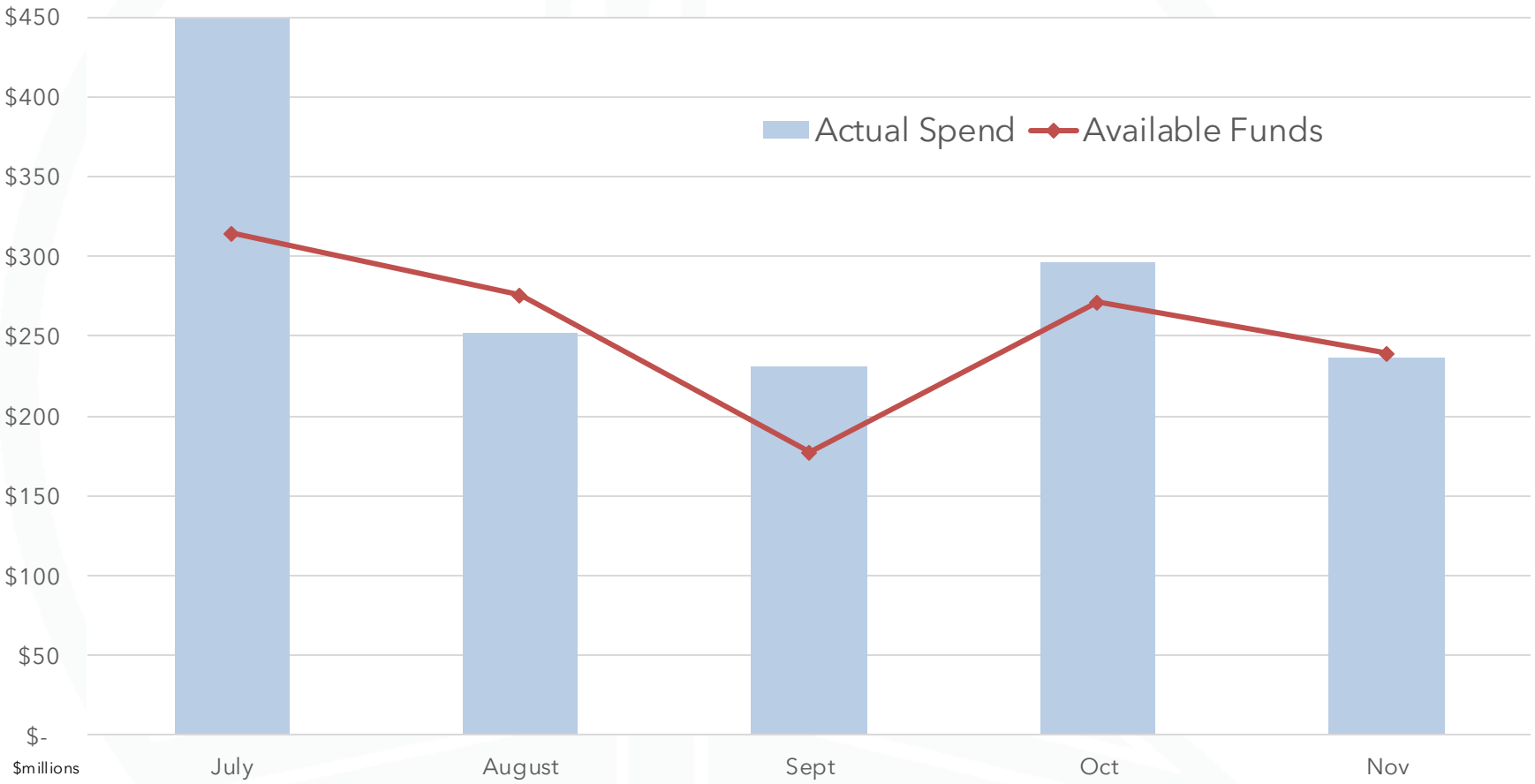
FY2026 Spending Year-to-Date – State Share Premium Accounts

	July 2025	August	September	October	November	Total
Pharmacy Claims (CVS/SilverScript)	$155,900,228	$86,848,810	$42,284,447	$118,763,597	$67,150,364	$470,947,446
Health New England Claims	$10,463,032	$9,207,144	$10,845,199	$8,643,885	$9,796,443	$48,955,703
Mass General Brigham Claims	$15,341,822	$10,937,060	$9,976,167	$13,880,707	$12,382,272	$62,518,028
Point32 Claims	$123,393,146	$67,525,210	$85,139,905	$71,644,297	$67,576,982	$415,279,541
Wellpoint Claims	$130,545,346	$65,409,812	$70,929,251	$72,002,202	$68,237,840	$407,124,452
Claims Subtotal	$435,643,575	$239,928,036	$219,174,970	$284,934,688	$225,143,901	$1,404,825,170
Basic/RMT Life Ins. Premiums	$1,708,694	$1,711,639	$1,710,748	$1,709,484	$1,711,930	$8,552,495
Tufts Medicare Preferred	$675,210	$675,347	$660,154	$689,991	$673,631	$3,374,334
UBH Optum EAP	$84,816	$84,816	$84,816	$84,816	$84,816	$424,080
ASO Administrative Fees	$10,179,737	$8,751,079	$8,753,809	$8,664,960	$8,660,163	$45,009,748
Other Costs	$236,170	$1,395,725	$307,288	$301,433	$83,208	$2,323,824
Dental/Vision Expenses	$1,011,564	$1,035,724	$1,036,816	$1,022,336	$990,953	$5,097,394
Other Expenses Subtotal	$13,896,191	$13,654,330	$12,553,632	$12,473,020	$12,204,702	$64,781,875
Combined Total	$449,539,766	$253,582,366	$231,728,602	$297,407,708	$237,348,603	$1,469,607,045

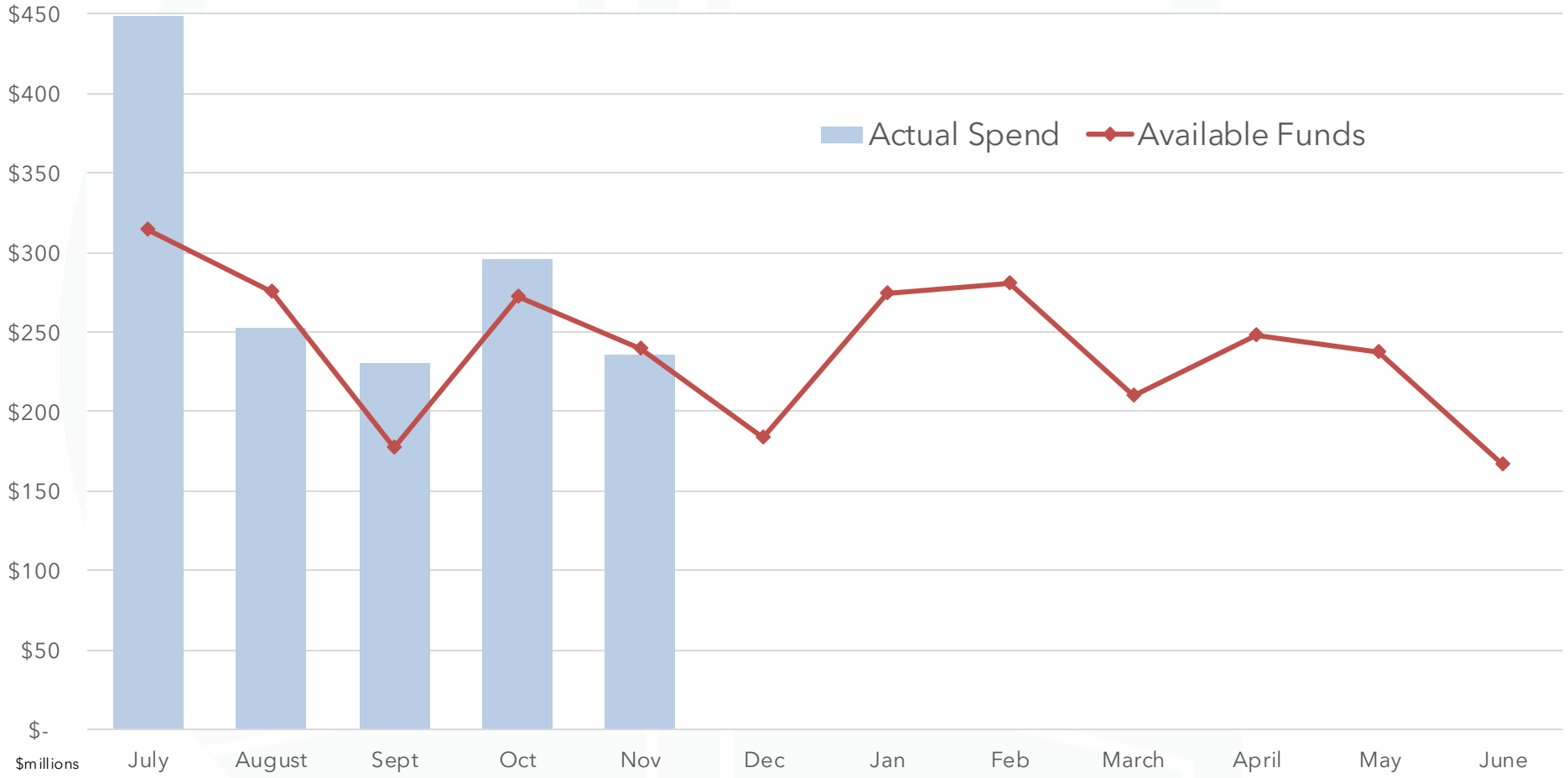
FY2026 Spending Year-to-Date – Enrollee Share Premium Account

	July 2025	August	September	October	November	Total
Pharmacy Claims (CVS/SilverScript)	$ -	$23,340,100	$11,035,054	$32,454,146	$19,123,494	$85,952,794
Health New England Claims	$3,180,048	$2,800,691	$2,565,305	$3,360,918	$3,640,543	$15,547,506
Mass General Brigham Claims	$4,756,236	$3,397,498	$3,102,013	$4,323,492	$3,861,557	$19,440,796
Point32 Claims	$ -	$19,524,496	$24,708,468	$20,793,702	$19,634,304	$84,660,970
Wellpoint Claims	$ -	$18,402,824	$20,030,453	$20,213,236	$23,118,802	$81,765,315
Claims Subtotal	$7,936,285	$67,465,609	$61,441,292	$81,145,494	$69,378,700	$287,367,381
Life/LTD Insurance Premiums	$6,441,022	$6,461,000	$6,515,991	$6,557,940	$6,569,727	$32,545,679
Tufts Medicare Preferred	$156,990	$157,233	$172,046	$142,589	$157,049	$785,906
UBH Optum EAP	$24,624	$24,624	$24,624	$24,624	$24,624	$123,120
ASO Administrative Fees	$2,108,270	$2,441,922	$2,440,673	$2,416,034	$2,417,779	$11,824,678
Other Costs	$9,019	$4,682	$4,264	$8,575	$4,873	$31,413
Dental/Vision Expenses	$2,439,157	$2,453,588	$2,469,199	$2,478,275	$2,483,974	$12,324,192
Other Expenses Subtotal	$11,179,081	$11,543,049	$11,626,797	$11,628,036	$11,658,025	$57,634,989
Combined Total	$19,115,366	$79,008,659	$73,068,089	$92,773,530	$81,036,725	$345,002,369

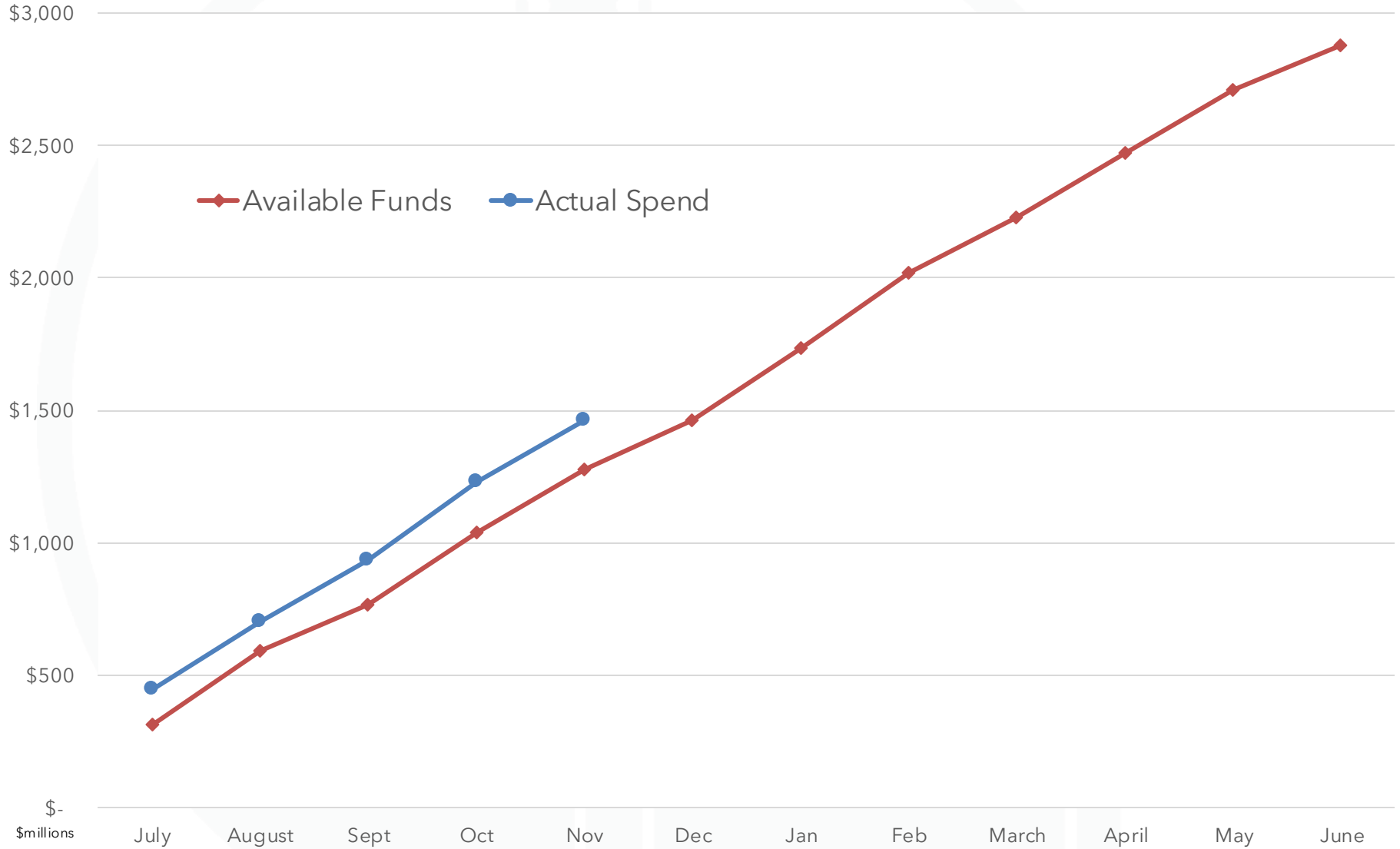
GIC State Appropriation for Health Premium Account FY2026 Projections vs. Actual as of November 30, 2025



GIC State Appropriation for Health Premium Account
FY2026 Available Funds vs. Actual Spending
as of November 30, 2025



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



V

Other Business/Adjournment

Valerie Sullivan, Chair
Matthew Veno, Executive Director

2026 Public Information Sessions

Register* today at Mass.gov/GIC

JANUARY	JANUARY	JANUARY
27	27	29
12:00 PM	6:00 PM	9:00 AM

*Please register for only one session. All sessions contain the same information.

2025 Group Insurance Commission Meetings & Schedule

January	February	February	April	May
16	6	27	17	15

June	September	October	November	December
18	18	16	20	18

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: Learnings from Other States

State spotlight: recent efforts to implement price controls

Oregon

- Oregon enacted reference-based price caps in 2017 for the state employee and teacher's plan. The plan was implemented in 2019.
- Reimbursements are limited to a cap of 200% of Medicare for in-network hospitals
- Within the first 27 months of the policy's implementation, the policy saved the state more than $107 million
- One study showed that hospital finances remain stable since initiation of the price caps

Montana

- Montana enacted reference-based price caps in 2016 for the public employee health plan
- Reimbursement rates were capped at 220%–225% of Medicare rates for inpatient services and 230%–250% for outpatient services
- The legislation achieved $47.8 million in savings in the first three years
- The price caps were repealed in 2022 following gubernatorial transition

State spotlight: recent efforts to implement price caps

Vermont

- Vermont passed legislation establishing upper limits on the amounts that hospitals can accept as payment for health care services, based on a percentage of Medicare
- These payment limits must be established by hospital fiscal year 2027
- The law also directs Green Mountain Care Board to ensure that the savings are passed along to rate payers through lower insurance premiums and to report on this annually.

Indiana

- Legislatively passed a commercial market price cap in 2025 containing two hospital price cap policies
- One policy requires nonprofit hospitals in the state's largest systems to bring their aggregate average inpatient and outpatient prices under the statewide average by June 2029
- The second policy requires the state's largest nonprofit hospitals to offer direct-to-employer contracting arrangements with price caps set at or below 260% of Medicare's reimbursement rates for inpatient and outpatient services

State spotlight: recent efforts to implement price caps

New Mexico

- New Mexico passed legislation to authorize hospital price caps in the state employee health plan
- As of July 1, 2025, the Health Care Authority would no longer reimburse urban in-network hospitals more than 200% and out-of-network hospitals more than 175% of what Medicare would pay for the same services.

North Carolina

- The state employee health plan's "Clear Pricing Project," a program that was voluntary for providers, ended in 2025
- PCPs and behavioral health providers were paid more than typical contracted rates under this program
- Other services were capped at reimbursed at lower than typical market rates and providers opted-out

State spotlight: recent efforts to implement price caps

Washington

- In 2025, Washington passed legislation (SB 5083) limiting how much Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans pay for inpatient and outpatient services to no more than 200% of the Medicare reimbursement rate for in-network services and no more than 185% of Medicare for out-of-network services, starting January 1, 2027
- The legislation also established minimum payment levels for primary care and behavioral health services delivered in the community to at least 150% of the Medicare rate.

Appendix

- Commission Members
- GIC Leadership Team
- GIC Goals
- GIC Contact Channels

Commission Members


Valerie Sullivan, Public Member, Chair


Michael Caljouw, Commissioner of Insurance

Darren Ambler, Public Member


Edward Tobey Choate, Public Member

Martin Curley, Public Member


Tamara P. Davis, Public Member


Jane Edmonds, Retiree Member

Gerzino Guirand, Council 93, AFSCME, AFL-CIO


Eileen P. McAnneny, Public Member


Bobbi Kaplan, NAGE, Vice-Chair


Matthew Gorzkowicz, Secretary of Administration & Finance

Kristin Pepin, NAGE

Dean Robinson, Massachusetts Teachers Association


Melissa Murphy-Rodrigues, Mass Municipal Association

Jason Silva, Mass Municipal Association


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

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**
- **Qualifying Events**
- **Information Changes**
- **Retirement**
- **Life Insurance**
- **Marriage Status Changes**
- **Premium Payments**
- **Long-Term Disability**
- **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