Obesity Groups Urge Massachusetts State Policymakers to maintain GIC and MassHealth Coverage for Comprehensive Obesity Care

March 2026

The Obesity Action Coalition (OAC), The Obesity Society (TOS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) strongly oppose Governor Healey and the Group Insurance Commission's (GIC) efforts to eliminate Medicaid and state employee coverage for GLP-1 medications. Our organizations strongly support coverage of Food & Drug Administration (FDA) – approved obesity management medications in the context of comprehensive obesity care for Medicaid beneficiaries under MassHealth and state employees under GIC. Improved access to obesity treatments that have been proven safe and effective, including nutrition counseling, behavioral and lifestyle interventions, FDA-approved obesity management medications, endo-bariatric procedures, and metabolic and bariatric surgery is critical to ensuring the health and productivity of all state residents.

For years, the State has been a leader in providing coverage for a broad spectrum of obesity treatment services, which has resulted in Massachusetts having one of the lowest obesity rates in the country. Despite this significant achievement, more than 27% of the population are living with obesity and another 35% are affected by overweight. Altogether, that's more than 62% of people living in Massachusetts who experience overweight or obesity.

MassHealth Coverage

The total cost of obesity in the United States is $1.7 trillion and healthcare costs are 34% higher for people with obesity. Maintaining access to obesity care will continue to help decrease the numerous illnesses and associated medical problems that plague Massachusetts residents, while improving health outcomes and healthcare savings. In addition, continuing Medicaid coverage for FDA-approved obesity management medications will ensure that Medicaid beneficiaries who are affected by obesity have access to affordable, individualized medical coverage for science-based treatments in the same way other chronic diseases are managed, allowing them to be treated with dignity, respect, and equality that is offered to their peers.

We know that obesity disproportionately affects people of color and of lower socioeconomical status which are important factors that often determine access to health care. Disparities further exacerbate Massachusetts obesity statistics and health outcomes with 35.4% of black and 34.3% of Hispanic state residents living with obesity compared to 27% of white residents. Persons with low incomes are more likely to be Medicaid recipients or uninsured, have poor-quality health care, and seek health care less often; when they do seek health care, it is more likely to be for an emergency.

A January 2026 study from the American Diabetes Association evaluated the clinical, economic, and social impacts of treating obesity among Medicaid adult beneficiaries. The study found that while medical savings offset only a portion of treatment costs, obesity interventions generate substantial social value through improved long-term health and productivity. These findings support expanded Medicaid coverage as a strategic investment in population health,

demonstrating value that challenges conventional short-term, budget-focused coverage decisions that currently limit access to evidence-based obesity treatments for millions of adults. For these reasons, we find Governor Healey's proposal to eliminate MassHealth coverage for GLP-1 medications penny wise and pound foolish.

GIC State Employee Coverage

State employees have also benefited from access to these medications for many years. The GIC has over 280,000 subscribers and 460,000 members and provides health insurance and other benefits to state employees and retirees, and their dependents and survivors. GIC also provides coverage to participating municipalities, Housing, and Redevelopment Authorities' personnel as well as to retired municipal employees and teachers in certain governmental units. Eliminating coverage would cause significant harm to individuals who are successfully managing their health and would also negatively affect the productivity and well-being of the state's workforce.

For these reasons, we were deeply concerned with Governor Healey's February 23rd letter to the GIC – urging commissioners to refrain from taking further action on any of her remaining budget proposals that may increase patient cost sharing as "these changes would disproportionately impact low- and fixed-income members and retirees who are already facing high costs of food, housing and energy; and could discourage use of cost-saving, preventative care." However, the Governor did make one exception when she urged the GIC to adopt her proposal to eliminate GLP-1 coverage for state employees. Despite this specific directive to the Governor's own hand-picked appointees, the commissioners only narrowly approved this motion by a 10-7 margin.

The lively debate that preceded this vote focused on many commissioners imploring GIC Chair Valerie Sullivan to schedule additional debate or delay the vote on removing GLP-1 coverage until more data could be gathered, especially given the tremendous feedback and concern that GIC members had received from state employees about this pending coverage policy change. Unfortunately, additional time for further review or discussion was not approved.

However, the less than two hours that was allotted for debate included some very passionate statements from both sides as to how the GIC was "approaching" some of its core mission pillars:

Use the GIC's leverage to innovate and otherwise favorably influence the Massachusetts health care market.

- "So when I get to GLP-1s, and I understand the effectiveness of these drugs, but we only have 18,000 members who are utilizing access to the medication for weight loss use, and out of 460,000 members, so roughly 3 ½ to 4% that's really a situation. For lack of better term, it's the tail wagging the dog, and it's a huge expense for the program. And we all know that the private market is moving away from this. They've dropped it quite a bit. And we are driving that demand as a huge plan, one of the largest in the country. We're driving demand, and demand keeps that price up, have plans remove that benefit, that demand will change, and the pricing will have to come down." – Darren Ambler (Public Member)
- "No one likes talking about limiting access to effective coverage. I think these are really hard decisions, and we've seen a lot of other folks have to grapple with this. So, the private market, MassHealth, MIIA and 35 other states have already acted in this way. But there's a long-term strategic reason here that I want to make sure that we can all see. We're hopeful that if we leverage the GIC market power, the private market and MassHealth collectively can push the price of GLP ones down to get access to this coverage, or our population, as the largest purchaser of health insurance in Massachusetts, we're a crucial part of the effort, and so if we continue to cover, there's no incentive for them to come work with us. If we cut coverage, collectively, we have market power to push those prices down to get access for our membership." – Dana Sullivan (Executive Office of Administration and Finance designee)
- "I'm open to working on strategies that use the GIC's market power to drive down pricing in the future, we should be doing that, but that's work for the future. Right now, today, we have 24,000 roughly members on a treatment that's managing the root cause of chronic disease. We can negotiate better prices without taking their coverage away while we do it." – Dean Robinson (Massachusetts Teachers Association)

Provide access to high quality, affordable benefit options for employees, retirees and dependents.

- "… to my knowledge, this is the first time the commission would be eliminating a proven, evidence-based kind of offering that's making a difference to our members." – Jane Edmonds (Retiree Member)
- "Candidly, I'm struggling with the GLP one decision, and I understand the value argument of not many people are using this, and so this is an easy thing to cut in order to see savings, but I kind of feel like that's the point of insurance, right? Is that we all pay in and then when we need it, that benefit is available to us. For me, it's like, what's next? Is it EpiPens? Is it epidurals? What are we going to decide is not worthy of being insured?" – Melissa Murphy-Rodrigues (Massachusetts Municipal Association)
- "I think that the data tells a more nuanced story of roughly 34,000 members on GLP, one over 15,700 are also on heart disease drugs. About 17,000 are on hypertension drugs. Obesity isn't separate from those conditions, it causes them, fat tissue, drives inflammation, insulin resistance, cardiovascular damage. So, when a doctor prescribes a GLP-1 for weight loss in these patients, they're treating the root cause of heart disease and hypertension, which we're paying to manage. If we vote to eliminate GLP ones, we're cutting off treatment while we keep paying for everything else, the cardiac drugs, the blood pressure medications, the ER visits, hospitalizations." -- Dean Robinson (Massachusetts Teachers Association)
- "The only thing I'd like to make sure that we understand is that the vote is to eliminate coverage solely for obesity. So, Dean, to your point about comorbidity, if a member has both heart disease, diabetes or any other conditions that are considered comorbid, our members will continue to get that coverage." – Valerie Sullivan (GIC Chair)

The above statements highlight the battle between the state being "fiscally responsible" and providing equal and fair access to effective science-based treatments. We wonder whether the outcome of the vote would have been the same if the benefit in question was related to cancer, heart disease or diabetes. In addition, we doubt that state covered beneficiaries with these conditions would be used as "leverage" in price negotiations between the Commonwealth and the pharmaceutical industry – in the same fashion the state is now doing with individuals affected by obesity.

In addition, we question the GIC relying on its own "informal survey of the market that indicates that coverage for GLP-1s to treat obesity in Massachusetts has retreated significantly since January 2025… and there's been some news coverage many carriers took steps to eliminate coverage consistent with the Department of Insurance March 4, 2025 guidance and eliminated it from their standard plan offering offerings" (Matthew Gorzkowicz, Secretary of Administration and Finance). In addition to this extremely discriminatory guidance from the DOI, we wonder why the GIC did not consider many of the positive developments in GLP-1 pricing and access during the last six months that states can take advantage of to reduce their costs for both Medicaid and state employee programs, including:

- The Center for Medicare and Medicaid Innovation BALANCE model that will allow Medicaid programs (that opt in) to purchase these GLP-1 medications at a monthly cost of $245 as early as May 2026.
- Pharmaceutical manufacturers have publicly announced their willingness to negotiate directly with states for their employee health plans.
- Finally, the market has already experienced downward price pressure throughout the past several months.

Treating Obesity is Good Public Policy

Throughout the last 5 years, there have been numerous studies and reports issued on the cost effectiveness of providing coverage for obesity treatment – with the most recent being the release of the October 29, 2025, Institute for Clinical and Economic Review (ICER) Evidence Report assessing the comparative clinical effectiveness and value of semaglutide and tirzepatide. ICER found all three medications to be highly cost-effective at conventional thresholds with incremental cost-effectiveness ratios estimated at $53,400 per quality-adjusted life year gained for tirzepatide, $61,400 for injectable semaglutide, and $69,300 for oral semaglutide.

Another example is the October 2025 report from Global Data, entitled the "Economic Benefits of Obesity Treatment," which assessed previous literature findings on the value of obesity treatments to help policymakers be better informed regarding coverage and policy decisions. This included 31 studies (2012–2025) on the economic value of four major interventions -- lifestyle programs, first-generation medications, modern medications, and metabolic and bariatric surgery. The report's key take away was that investing in effective obesity treatments not only improves health outcomes and quality of life but also delivers meaningful savings. The estimated annual medical savings (adjusted to 2025 dollars; varies by insurance type) would be as follows: $200-$1,220 for lifestyle programs and first-gen medications; $760-$4,720 for modern medications; and $940-$5,830 for metabolic and bariatric surgery.

The University of Southern California Schaeffer Center study (2023) on the "Benefits of Medicare Coverage for Weight Loss Drugs" found that treating obesity can reduce diabetes (-8.9%), hypertension (-2.3%), heart disease (-2.6%), cancer (-1.3%), and disability (- 4.7%) over 10 years in private insurance coverage and Medicare. These results would also likely apply to state employee and state Medicaid programs.

In addition, a recent AON study of 139,000 U.S. employees revealed that patients treated with GLP-1 medications experienced a 7% lower medical cost trend by year two compared to similar patients who did not receive treatment for their obesity. In contrast, the untreated group saw their medical cost trend rise to 14%. This is a 50% reduction in health care spending for patients taking obesity management medications. Most notably, GLP-1 use led to a greater than 40% reduction in major adverse cardiac events such as heart attacks and strokes and significantly reduced the incidence of diabetes—outcomes that directly benefit both patient lives and the state's healthcare expenditures. The study was so impactful that the benefits consulting firm started a program to cover these obesity management medications for their own employees.

The goal of healthcare is not simply to save money, but to improve the health and quality of life of people. Current MassHealth and GIC coverage for obesity management medications as part of a comprehensive obesity care plan meet these goals. Therefore, we strongly urge the legislature to oppose Governor Healey's efforts to hold obesity care to a different standard than other medical conditions when it comes to insurance coverage.

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