Health Insurance Outlook:

Hampshire County Group Insurance Trust

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I. Introduction

The Hampshire County Group Insurance Trust (HCGIT) is a Joint Purchasing Group (JPG) that provides health insurance coverage to 73 municipal entities across Franklin, Hampshire, Hampden, and Worcester Counties. Established under Section 12 of Chapter 32B of the Massachusetts General Laws, the Trust facilitates the joint purchase of insurance for towns, cities, fire districts, regional school districts, water districts, and community development corporations. While these entities are members of the Trust, their employees are part of the respective units and must receive uniform rates and health insurance products unless specified otherwise in a collective bargaining agreement. HCGIT serves over 12,000 active and retired municipal employees and their eligible dependents, offering benefits such as health insurance, basic life insurance, voluntary life insurance, voluntary dental insurance, voluntary disability insurance, and long-term care insurance.

II. Plan Administration

Municipalities typically administer benefits under self-insurance, fully insured coverage, or through Joint Purchasing Groups (JPGs) like the HCGIT. Being self-insured means being financially responsible for the performance of the risk pool. In years when claims are stable or low, the employer builds reserves, which can help offset costs during years of high claims. Claims activity typically fluctuates year over year. In a fully insured model, an employer purchases health insurance through a commercial insurer, transferring both risk and administrative responsibilities to the insurer. While premiums and costs in this model are more predictable, rates can be significantly higher due to increased administrative and insurance margins, with fewer opportunities for shared savings when claims are low.

Several statewide group purchasers offer pooled arrangements that vary in governance and operation through JPGs, including but not limited to the HCGIT, the Massachusetts Interlocal Insurance Association (MIIA), the Group Insurance Commission (GIC), and the Massachusetts Strategic Health Group (MSHG). Some purchasing groups allow municipalities to participate in a large pool, spreading risk among participants (e.g., GIC). Others blend the experience of individual municipalities with the performance of the general pool (e.g., MIIA), while some groups maintain a pooled arrangement where the entity remains self-insured and is responsible for its specific claims risks (e.g., MSHG). The chart below compares the key differences among these types of joint purchasing groups.

Exhibit A: JPG Comparisons (HCGIT, MIIA, GIC and MSHG)

JPG	Plan Design	Rating	Acceptance of New Entities
HCGIT	All participating entities have the same plan design voted	All entities have the same premium rates with shared risk.	At the discretion of HCGIT

	by the Insurance Advisory Committee.		
MIIA	Each entity can determine their own plan design.	Each entity is rated on their claims experience, with some risk sharing, such as credibility factor, rate ranges, and pooling of large losses.	At the discretion of MIIA
GIC	All entities have the same plan design set by the Commissioners.	All entities have the same premium rates with shared risk.	Automatic acceptance with a signed PEC agreement (utilizing MGL c. 32B Section 19 or Sections 21-23.
MSHG	Each entity can determine their own plan design.	Each entity is self-insured and carries its own claims risk, while leveraging combined purchasing for administrative fees and stop-loss premiums.	At the discretion of MSHG

HCGIT operates its health plans on a self-funded basis, directly paying medical claims for its members instead of making fixed premium payments to an insurance company. To manage network access, claims processing, and other administrative tasks, the Trust engages a Third-Party Administrator (TPA), currently Blue Cross Blue Shield (BCBS). To mitigate risks associated with high-cost or catastrophic claims, stop-loss insurance is secured through Amwins. Given the Trust's size, a dedicated full-time staff oversees claims payments and operational management while providing direct support to each municipal participant.

The Trust also manages its prescription drug coverage directly through CVS Caremark, ensuring cost-effective options for its members. Since 2021, the Trust has initiated procurement efforts twice to secure a competitive Pharmacy Benefit Manager (PBM) under a carve-out structure, working in collaboration with its pharmacy consultant, Truveris. CVS Caremark acts as the PBM, serving as an intermediary that manages prescription drug benefits for health insurers and employers by negotiating prices with manufacturers, creating formularies, and processing claims to control costs and ensure access to medications. Truveris assists in securing favorable contract terms, rebates, and pharmacy claims audits, while also conducting periodic market checks to evaluate the most competitive PBMs for the Trust and its members.

To achieve the highest possible level of health insurance benefits at the most consistent and lowest price, HCGIT focuses on attractively priced Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans that emphasize early treatment while remaining cost-effective for both employees and employers. This strategy includes minimizing plan varieties, managing medical risks, and implementing and expanding wellness initiatives designed to enhance employee health through preventive measures.

III. HCGIT Key Offerings

When comparing HCGIT's benefits and rates to other municipal market options, the Trust remains cost-effective, often providing richer benefits even with the July 1 rate adjustment and the additional mid-year increase effective October 1 for FY26. Like many employers, the Trust will continue to face sharp surges in healthcare costs and is taking necessary steps to ensure financial stability for its members. Efforts are underway to re-examine pharmacy administration due to recent increases in prescription drug utilization, explore new plan offerings in the marketplace, and leverage competitive pricing from carriers.

Exhibit B: HCGIT Competitive Advantages

HCGIT Offerings	
Key Highlight	**Description**
Cost-Effective Coverage	Offers competitively priced health insurance plans (HMO and PPO) with enhanced benefits compared to market alternatives. Additionally, provides a supplemental plan (Medex 2) alongside Blue Medicare Rx PDP for comprehensive coverage tailored to Medicare-eligible retirees.
Wide Network Access	Provides access to extensive provider networks, reducing out-of-pocket costs for members.
Comprehensive Benefits	Includes health, life, dental, disability, and long-term care insurance for employees and dependents.
Expert Management	Dedicated staff and partnership with BCBS ensure efficient claims processing and administrative support.
Wellness Initiatives	Expanding preventive care programs to improve employee health and reduce long-term costs.

IV. Healthcare Market Trends

The Massachusetts healthcare system faces many challenges. Numerous dynamics are influencing affordability, spending, and access, as follows:

- Insurer consolidations are limiting market options for employers.
- New MassHealth supplemental payments are driving up spending.
- Acute hospital operating margin growth and administrative expenses are straining health system budgets.

- Hospitals are experiencing high workforce shortages, including nurses, doctors, and administrative staff, which limits access to care.
- Providers are demanding higher prices in insurance negotiations.
- Mergers & Acquisitions among hospital and provider groups are limiting competition and monopolizing market prices.
- Premiums and member cost-sharing are outpacing wages and salaries.
- Financial troubles seen across health systems like Steward have raised concerns about potential hospital closures and access to care.

As a result of these market dynamics, family health insurance rates in Massachusetts are now among the second highest in the United States and nearly half of all residents are having difficulty affording care. Healthcare is experiencing unprecedented cost pressures, with surging medical expenses, inflation, and pharmaceutical spending contributing to unsustainable rate increases for most public- and private-sector employers. The primary reasons for these cost hikes include:

1. **Increased Demand for Healthcare Services:** Key factors driving medical demand include rising chronic disease rates, aging populations, behavioral health issues, inflation, primary care shortages, and advancements in medical technologies.

2. **Higher Prices for Medical Procedures:** Significant contributors to rising costs are inflation, labor shortages, medical equipment expenses, administrative costs, and technological advancements.

3. **Surges in Prescription Drug Pricing (including GLP-1s):** Factors such as specialty drugs, high development costs, mergers and acquisitions, patent protections, and limited competition are driving pharmacy spending. For instance, from January to September 2025, the Trust spent approximately $4.5 million on GLP-1s for weight loss alone.

4. **Hospital and Health System Costs:** Outpatient care, chronic disease management, emergency room usage, administrative expenses, workforce shortages, high drug prices, technology costs, mergers, and increases in elective surgeries are significantly impacting pricing and insurance contract negotiations.

5. **Provider Costs:** Low Medicare and Medicaid reimbursements, industry consolidation, medical technology expenses, administrative costs, costly treatments, labor shortages, and expensive medications are driving up insurance rates.

6. **Insurance Premiums:** Consolidations among insurers, rising provider and hospital costs, pharmaceuticals, increased utilization, and chronic disease management are leading to significant rate increases across all health insurers.

V. Municipal Rate Trends

Massachusetts employers experienced substantial rate increases for FY26, among the highest in recent decades, influenced by the outlined market dynamics. This trend is expected to continue into the coming years. Below is a five-year review of the Trust's rates compared to other joint purchasing groups, along with pertinent insurance market trends.

Exhibit C: Average Rate Renewal Five-Year Review

Please note that trends vary by insurer, funding arrangement, and plan type.

Average Rate Renewal Trends: Five-Year Look Back					
Fiscal Year	**HCGIT Renewal**	**GIC Average**	**MIIA Average**	**Medical Trend***	**Pharmacy Trend***
FY26	18-20% + 20% Midyear	10%–17% (11.7% Avg)	10%–20% (14.8% Avg)	8%–10%	14%–17%
FY25	8.0%	9.6%	6.6%	8%–10%	14%–18%
FY24	6.0%	5.16%	5.6%	7%–10%	13%–18%
FY23	0.0%	5.4%	3.7%	7%–10%	9%–15%
FY22	-2.0%	2.78%	2.9%	6%–10%	10%–15%

**Please be aware that medical and pharmacy trends differ among Massachusetts-specific health insurers, funding arrangements, and formularies. Additionally, these ranges reflect average values.*

HCGIT's claim experience, including high-cost claims, remains aligned with or below market benchmarks. This indicates that HCGIT's health insurance plans are performing comparably to or better than typical market plans within a similar book of business. Per Member Per Month (PMPM) is a metric used in health insurance to represent the average cost or revenue associated with each member per month. For example, in FY25, 17% of total medical costs were driven by claims exceeding $150,000, which is still below the BCBS benchmark level of 19%. The Trust's overall net medical cost in FY25 was $540 PMPM, an increase from $479 in FY24, yet it remained below the BCBS FY25 benchmark of $614 PMPM.

Historically, the Trust's claims stability enabled effective management of rate increases. However, broader health care inflation, intensified by high prescription drug utilization, has led to a funding shortfall for FY26. Between 2024 and 2025, the Trust observed a rise in cancer cases, increased behavioral health service utilization, and significant surges in high-cost prescription drugs, particularly GLP-1 medications for weight loss. Gross pharmacy spending rose over 20%, with specialty drugs now accounting for 51% of total drug spending, following a 15% increase in specialty utilization across areas such as anti-obesity, psoriasis, rare disorders, and oncology. As a result, a mid-year rate adjustment was necessary, and the anti-obesity

medications were officially removed as of October 1, 2025. While this elimination generated financial savings, it also led CVS Caremark to reduce the Trust's negotiated rebates more than expected. Given these factors, the Trust must proceed cautiously in adjusting premiums for FY27 and beyond, considering the ongoing challenges in the health insurance market. Nevertheless, the Trust's offerings remain competitive compared to other municipal offerings, including the GIC's Benchmark plan, despite recent premium adjustments. ***See Appendix A: FY26 HCGIT & GIC Comparisons.***

VI. Outlook: FY27 and Beyond

Health insurance costs have become unsustainable for municipalities and many employers across Massachusetts, regardless of their funding arrangements. Projections for FY27 indicate medical costs will rise between 8% and 12%, depending on the specific plan and insurance carrier. Pharmacy costs are also expected to persist, with trends averaging between 11% and 18%, depending on the funding arrangement, insurance carrier, and formulary. To address these rising costs and the financial challenges facing the Trust, HCGIT has initiated a health plan marketing effort to evaluate both local and national carriers, ensuring competitive rates and continuity of benefits for members. The Trust will also re-evaluate its pharmacy administration to enhance utilization management and audit oversight. Additionally, HCGIT will conduct a market assessment to explore alternative Pharmacy Benefit Manager (PBM) arrangements and more competitive contract terms.

Despite the projected rise in healthcare costs for FY26 and beyond, HCGIT has maintained stability in medical claims activity among its members. The Trust is actively addressing the implications of the ongoing healthcare crisis in the market. It will continue to adapt its strategies and programs to minimize the impact on members by ensuring compliance and conducting audits across all plans, including claims and dependent coverage. Given HCGIT's historical stability outside of FY26, the Trust is well-positioned for recovery in the upcoming fiscal year, thanks to its stable risk pool and proactive response efforts. To ensure solvency in the years ahead, collaboration and staying informed about emerging trends will be essential.

Appendix A: FY26 HCGIIT & GIC Comparisons

		HCGIT BCBSMA 7/1/2025 - 6/30/2026	
PLAN DESIGN		**BCBSMA HMO Blue New England**	**BCBSMA Blue Care Elect Preferred PPO**
PCP Required / GateKeeper Plan		Yes	No
Plan Year Deductible	*Network*	$0 / $0	$0 / $0
Single / Family	*Non Network*	***Network Coverage Only***	$250 / $500
Embedded/Non-Embedded		N/A	N/A
Plan Year Out of Pocket	*Network*	$5,000 / $10,000	$5,000 / $10,000 Network and Non
Single / Family	*Non Network*	***Network Coverage Only***	Network Combined
NETWORK BENEFITS - *Member Responsibility*			
Office Visit Co-pay - Preventive Care		Covered at 100%	Covered at 100%
Office Visit Co-pay - PCP		$20 Copay	$20 Copay
Office Visit Co-pay - Specialist		$35 Copay	$35 Copay
Emergency Room Copay		$100 Copay	$100 Copay
Urgent Care Copay		$35 Copay	$35 Copay
Diagnostic X-rays & Lab Tests (excl. Hi-Tech Imaging)		Covered at 100%	Covered at 100%
Hi-Tech Imaging		$100 Copay	$100 Copay
Inpatient Hospitalization		$250 Copay per Admission	$250 Copay per Admission
Outpatient/Day Surgery		$150 Copay per Admission	$150 Copay per Admission
Prescription Drug Vendor		**CVS Caremark**	**CVS Caremark**
Prescription Drug Deductible		$100 / $200 Deductible	$100 / $200 Deductible
Prescription Drug Out of Pocket Maximum		$5,000 / $10,000	$5,000 / $10,000
Retail Rx - Copays for 30 day supply		$10 / $30 / $65	$10 / $30 / $65
Mail Order Rx - Copays for 90 day supply		$25 / $75 / $165	$25 / $75 / $165
WORKING RATES		**10/1/2025 - 6/30/2026**	
Employee		$1,007.00	$1,180.00
Employee Plus One Dependent		$2,344.00	n/a
Family		$2,888.00	$3,221.00

MASSACHUSETTS GIC Sample Plans (HP Explorer is the Benchmark Plan under MGL c. 32B Sections 21-23) 7/1/2025 - 6/30/2026		
HEALTH NEW ENGLAND **HMO** *Local to Western MA Only*	**HPHC** **Harvard Pilgrim Access America** **PPO** *National*	**HPHC** **Harvard Pilgrim Explorer** **POS** *New England Only*
Yes	No	Yes
$400 / $800	$500 / $1,000	$500 / $1,000
Network Coverage Only	$500 / $1,000	$500 / $1,000
Embedded	Embedded	Embedded
$5,000 / $1,000	$5,000 / $10,000	$5,000 / $10,000
Network Coverage Only	$5,000 / $10,000	$5,000 / $10,000
Covered at 100%	Covered at 100%	Covered at 100%
$20 Copay	$20 Copay	**T1:** $10 / **T2:** $20 / **T3:** $40 Copay
T1: $30 / **T2:** $60 Copay	$45 Copay	**T1:** $30 / **T2:** $60 / **T3:** $75 Copay
$100 Copay after Deductible	$100 Copay after Deductible	$100 Copay after Deductible
$20 Copay	$20 Copay	$20 Copay
$0 after Deductible	$0 after Deductible	$0 after Deductible
$100 Copay after Deductible	$100 Copay after Deductible	$100 Copay after Deductible
$275 Copay per Admission after Deductible *Max 1 Copay per CY Quarter*	$275 Copay per Admission after Deductible *Max 1 Copay per CY Quarter*	**T1:** $275 / **T2:** $500 / **T3:** $1,500 Copay per Admission after Deductible *Max 1 Copay per CY Quarter*
$150 Copay after Deductible for Eye/GI Procedures: Freestanding Facilities $250 Copay after Deductible: All Other OP Surgery/Procedures	$150 Copay after Deductible for Eye/GI Procedures: Freestanding Facilities $250 Copay after Deductible: All Other OP Surgery/Procedures	$150 Copay after Deductible for Eye/GI Procedures: Freestanding Facilities $250 Copay after Deductible: All Other OP Surgery/Procedures
CVS Caremark	**CVS Caremark**	**CVS Caremark**
$100 / $200 Deductible	$100 / $200 Deductible	$100 / $200 Deductible
Medical OOP Max Applies to Rx	Medical OOP Max Applies to Rx	Medical OOP Max Applies to Rx
$10 / $30 / $65 after RX Deductible	$10 / $30 / $65 after RX Deductible	$10 / $30 / $65 after RX Deductible
$25 / $75 / $165 after RX Deductible	$25 / $75 / $165 after RX Deductible	$25 / $75 / $165 after RX Deductible
7/1/2025-6/30/2026		
HEALTH NEW ENGLAND **HMO Local to Western MA Only**	**HPHC** **Harvard Pilgrim Access America** **PPO National**	**HPHC** **Harvard Pilgrim Explorer** **POS New England Only**
$859.36 n/a $2,061.16	$1,438.62 n/a $3,208.78	$1,187.97 n/a $2,941.06

Please note that the chart above serves as an illustrative comparison featuring the GIC benchmark plan alongside other plans that are reasonably assumed for migration for Active and non-Medicare Retirees, based on geographical parameters.

Reference Guide

Glossary of Healthcare Terms		
Term	**Category**	**Definition**
Copayment (co-pay)	Healthcare services	A fixed amount that a plan member pays out-of-pocket for a covered healthcare service. It is a form of cost-sharing between a member and their insurance company.
Deductible	Healthcare services	The amount of money a member must pay out-of-pocket for covered medical expenses before a health insurance plan starts to cover costs.
Coinsurance	Healthcare services	The percentage of the cost a member pays after the deductible is met and before insurance pays the rest.
Out-of-Pocket Maximum	Healthcare services	The total amount a member pays for covered services each year.
Allowed Amount	Healthcare services	The maximum amount insurance will pay for a covered service.
Exclusions	Healthcare services	Conditions or circumstances under which insurance will not provide benefits.
Essential Health Benefits (EHB)	Healthcare services	A set of benefits required by the Affordable Care Act.
Health Maintenance Organization (HMO)	Plan-type	A type of health insurance plan that provides healthcare services for a fixed annual fee, typically limiting coverage to a network of providers and requiring members to elect a primary care physician (PCP). HMOs are a type of managed care organization, meaning they focus on controlling costs and coordinating care. HMOs have a network of healthcare providers who agree to accept payment at a certain level for their services.
Preferred Provider Organization (PPO)	Plan-type	A type of health insurance that offers a network of preferred providers at discounted rates. PPO members pay less when they use providers within the network, also known as in-network providers. PPOs provide some coverage for out-of-network providers, but usually at a higher rate.

Point of Service (POS)	Plan-type	A type of health insurance that combines features of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). This plan type offers flexibility to see in-network and/or out-of-network providers, but at potentially higher costs for out-of-network care.
High-Deductible Health Plan (HDHP)	Plan-type	A health insurance plan with a high annual deductible and lower monthly premiums than traditional plans. HDHPs are often paired with health savings accounts (HSAs) to save pre-tax money for health expenses like deductibles, coinsurance, prescriptions, dental care, and eyewear. For 2025, the IRS defines the deductible as at least $1,650 for an individual and $3,300 for a family.
Fully Insured	Funding arrangement	A group health plan in which the employer purchases insurance from a commercial insurer (e.g., Blue Cross, Point32), and the insurer assumes the financial risk and pays medical claims in exchange for premiums. Fully insured plans can be more expensive than self-funded options, as they include the insurance company's profit margins and overhead costs. Premiums can increase at renewal, based on overall claim trends within the insured pool, age demographics, and other factors.
Self-Insured (self-funded)	Funding arrangement	A group health plan in which the employer directly assumes the financial risk and pays employee medical claims rather than an insurance company. Self-funding offers potential cost savings and flexibility in establishing a preferred plan design. This can help improve cash flow and avoid paying insurance company premiums and profit margins, allowing employers to save money. However, employers bear the full financial risk of healthcare claims, which can fluctuate year to year.
Third-Party Administrator (TPA)	Self-insurance	An organization that handles the administrative tasks and claims processing for an employer's self-funded health plan, acting as an intermediary between the employer and healthcare providers.

Stop Loss Insurance	Self-insurance	A type of policy that protects self-insured employers from catastrophic claims that exceed predetermined levels. If total claims exceed the limit, the stop-loss insurer either covers the claim or reimburses the employer.
Projected Claims	Financial Analysis	An estimated dollar amount of claims anticipated to be paid based on the plan's characteristics and historical data, trended forward to the projection period.
Per Member Per Month (PMPM	Financial Analysis	A metric used in health insurance to represent the average cost or revenue associated with each member over a month. It is calculated by dividing total costs or revenues, such as premiums or claims, by the number of members. PMPM provides a standardized way to assess financial performance, manage budgets, and evaluate the impact of healthcare utilization on overall costs.
Pharmacy Benefit Manager (PBM)	Pharmacy	An intermediary that manages prescription drug benefits for health insurers and employers. They negotiate prices with drug manufacturers, create formularies, and process claims to control costs and ensure access to medications. Additionally, PBMs implement utilization management strategies to promote appropriate prescribing practices.