Municipal Health Insurance & Massachusetts Statutes – Q&A Handout:

Hampshire County Group Insurance Trust

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Benchmark Plans

What is a benchmark plan and why is it important?
Benchmark plans serve as a standard for health insurance coverage. By aligning their plans with benchmarks, employers ensure that benefits meet specific requirements and remain competitive in the market. It's important to note that benchmark plans can vary by employer sector.

What are the municipal benchmark plans in Massachusetts?
In Massachusetts, the municipal benchmark plans are established under M.G.L. Ch. 32B, §21–23, which are the Group Insurance Commission's (GIC) most enrolled plans. They are currently as follows:

- Non-Medicare benchmark plan: Harvard Pilgrim Explorer
- Medicare benchmark plan: Wellpoint Medicare Extension

Collective Bargaining & Health Insurance

What is the purpose of M.G.L. Chapter 150E?
Chapter 150E authorizes municipal entities to negotiate health insurance benefits as part of each union's collective bargaining agreement (CBA). Negotiable items include plan design, contribution splits, Health Reimbursement Accounts (HRAs), opt-out provisions, and other benefits such as life and dental insurance. When negotiating under 150E, retirees and non-union personnel benefits are set by the appropriate public authority.

What is M.G.L. Ch. 32B Section 19 and how does it affect negotiations?
Section 19 allows coalition bargaining through a Public Employee Committee (PEC), comprising one member from each collective bargaining group, plus a retiree representative. The PEC can negotiate plan design, premium splits, and additional benefits. The municipal entity's appropriate public authority must adopt the statute. Agreements must be ratified by a weighted majority of the PEC. Section 19 is used to negotiate both active employee and retiree benefits. If an agreement is not reached with the PEC, no changes can be implemented.

How does a municipal entity terminate using Section 19?
The statute requires agreement between the municipal entity and the PEC to terminate under Section 19. However, a sunset clause can be included in the PEC agreement to terminate Section 19 at the end of the agreement.

What is M.G.L. Ch. 32B Sections 21–23 and how does it affect negotiations?
These sections allow municipal entities to negotiate with a PEC, similar to Section 19. They allow negotiation of plan design changes (e.g., deductibles and copayments) or

the option to enter the GIC. Municipal entities can propose plan design changes that do not exceed the cost-sharing components of the GIC benchmark plans. In addition, there is a requirement that up to 25% of the total first-year savings be given back to employees/retirees to offset any increased out-of-pocket expenses. Following a very specific, structured timetable, the municipal entity and the PEC enter negotiations for a 30-day period. If no agreement is reached by the end of the 30-day period, the municipal entity's proposal is submitted to a 3-person panel. The panel will review the proposed benefits and the mitigation plan. If the proposal is in accordance with the statute, they will allow the municipal entity to implement the proposed changes.

How do municipalities adopt Sections 21–23?
Adoption requires:

1. A vote by the appropriate public authority (i.e., Select Board, School Committee, City Council, etc.)
2. Unions and retirees (through the Retired State, County Municipal Employees Association) must be notified of the intent to vote no later than 2 days prior to the vote.

What is the process for negotiating with unions under Sections 21-23?
Notification and voting processes for unions include (with a very detailed and specific timeline):

1. A proposal must first be presented to the Insurance Advisory Committee (IAC).
2. A Public Employee Committee (PEC) is then established (if it doesn't already exist); once the PEC members have been identified, the proposal must then be submitted to all members.
3. Negotiations take place within a 30-day expedited bargaining period.
4. If no agreement is reached, a three-person review panel evaluates proposed changes to ensure they comply with the statute in terms of benefit design and mitigation plan.

Who comprises the three-person review panel?
The panel is composed of three members: one representative from the municipal entity, one from the PEC, and an impartial member. The State will provide both the municipal entity and the PEC with a list of three candidates for the impartial member. If the two parties cannot reach an agreement on which of the three candidates to select, the State will make the final decision.

Can contribution splits be negotiated through Sections 21–23?
No. The contribution structure remains negotiable under Chapter 150E.

What is the mitigation fund and is it required?
When using the expedited process, municipalities must allocate up to 25% of the first year's savings to employees and retirees. Funds may be distributed in various ways, for

example: premium holidays, HRAs, flat payments to each participant, or reimbursement of certain copayments.

If a municipality previously adopted Sections 21–23, must it do so again?
The law specifies that the appropriate public authority is required to adopt the provision only once. However, there is ambiguity regarding whether a revote is necessary to utilize the statute after its initial adoption. It is advisable for a municipal entity to consult its legal counsel, as interpretations of this matter may vary.

Cost Trends & Municipal Strategies

Why are healthcare costs rising?
Key drivers include increased demand for services, expensive medical technologies, rising prescription prices, administrative costs, and higher provider expenses.

What are municipal employers doing to address rising costs?
Strategies include reducing medical claims, managing pharmacy costs, exploring alternative plans such as High-Deductible Health Plans (HDHP), implementing targeted solutions for chronic conditions, promoting wellness initiatives, encouraging the use of cost-effective providers, optimizing healthcare networks, and enhancing communication with employees and retirees to help them become informed consumers.

HCGIT-Specific Information

Why has the Trust experienced higher-than-usual rate increases since FY26?
Contributing factors include increased utilization, rising hospital costs, higher drug prices, GLP-1 medications for weight loss, and high-cost claims for cancer, behavioral health, and musculoskeletal conditions.

What has the Trust done this year to combat rising costs?
Actions include evaluating carriers, reviewing pharmacy programs, developing new medication purchasing strategies, eliminating GLP-1s for weight loss, and reassessing stop-loss coverage.

What will the Trust do moving forward to control costs?
Planned strategies include, but are not limited to, reducing medical claims, managing pharmacy expenses, exploring alternative plans, utilizing point solutions to effectively address chronic conditions, promoting wellness initiatives, establishing partnerships with providers, conducting fiduciary audits, and enhancing education for member units on market trends and strategic approaches.

Can the Trust consider a lower premium increase without changing benefits?
While the Trust understands the desire to minimize premium increases, significant rises

in healthcare costs and depleted HCGIT reserves make it challenging to reduce increases without risking financial stability for the group. Aligning benefits with market trends is crucial to prevent higher-than-usual increases in the future.

If the Trust adopts recommended benefit design changes, will there be time to negotiate with unions?
Yes, most benefit decisions are finalized between January and February in the municipal market. If bargaining units negotiate under Sections 21-23, the expedited negotiation process aligns with the July 1 effective date for benefits, providing adequate time for negotiation. Templates from Hilb can assist units in evaluating savings and preparing for mitigation distribution.

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.