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FY27 ANNUAL REPORT & FY28 OUTLOOK

Hampshire County Group Insurance Trust

Annual review of HCGIT's renewal actions, rates and municipal market options

October 23, 2026

A glossary of health insurance terms is included in the Reference Guide at the end of this report.

FY27 AT A GLANCE

A Year of Recovery

After reserves fell from $20 million to under $5 million and the Trust came close to insolvency in FY26, HCGIT took decisive action for FY27 to restore financial stability while keeping benefits competitive. Every step since the FY26 renewal cycle has been aimed at rebuilding the Trust's reserves; see "How HCGIT Is Rebuilding Its Reserves" in Section III. The Trust is no longer operating month to month financially, and its FY27 reserve target is $1 million. The Trust has stabilized and is on track to meet that target and continue rebuilding its reserves in the years ahead.

12.48%
FY27 rate increase, below the 16% previously projected

$3.4M
Projected pharmacy savings, with no change to the drug formulary

$6.9M
Trust ending balance, June 2026; FY27 budget balanced

6.0%
Medex 2 increase for calendar year 2027 ($525.00)

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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 61 municipal entities across Berkshire, 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 approximately 10,000 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 by the Insurance Advisory Committee.	All entities have the same premium rates with shared risk.	At the discretion of HCGIT
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 of Massachusetts (BCBSMA). To mitigate risks associated with high-cost or catastrophic claims, the Trust maintains specific stop-loss insurance at a $400,000 deductible per member; for FY27, the stop-loss program was awarded to BCBSMA. Since December 2025, Hilb Group has served as the Trust's Executive Director (consultant), overseeing claims payments and operational management while providing direct support to each municipal participant.

The Trust also manages its prescription drug coverage directly, with CVS Caremark serving as its Pharmacy Benefit Manager (PBM). A PBM serves 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. Beginning in FY27, the Trust moved its pharmacy benefit to Employers Health, a national purchasing coalition, to secure stronger contract terms and rebates through CVS Caremark. The drug formulary did not change as part of this move.

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. FY27 Renewal: Actions Taken This Year

FY26 was the most challenging year in the Trust's history. Rising medical costs and a surge in high-cost prescription drugs, particularly GLP-1 medications for weight loss, drew reserves down from $20 million in January 2024 to under $5 million, and the Trust came close to insolvency. To keep the Trust solvent, a 20% mid-year rate adjustment took effect October 1, 2025, and weight-loss GLP-1s were removed from coverage as of the same date.

As a result of the FY26 financial crisis, HCGIT changed its leadership structure, appointing Hilb Group as its Executive Director (consultant) as of December 2025. Due to the unprecedented double-digit increases and uncertainty over whether the group would continue, HCGIT lost 12 member units. However, this loss of membership did not impact the overall claims performance of the group.

For FY27, the Trust focused on restoring financial stability while keeping benefits competitive, through the following actions.

Active Employees and Non-Medicare Retirees

Exhibit B: FY27 Renewal Actions

Action	Description
Vendor & Network Stability	Issued a Request for Proposal (RFP) to the health insurance market and, following the review, remained with BCBSMA, preserving cost competitiveness, quality service, and network continuity for members.
Pharmacy Benefit Strategy	Moved the pharmacy benefit to the Employers Health coalition for stronger contract terms and rebates, **without changing the drug formulary**. CVS Caremark remains the PBM. Projected savings: **$3.4 million**.
Plan Design	Introduced a $250 / $500 annual medical deductible and modest copay increases, aligned with municipal benchmarks.
Expanded Dependent Coverage	Effective July 1, 2026, in-network coverage is available for registered dependents living outside the New England service area under the Network Blue New England plan.
Stop-Loss Program	Awarded the FY27 stop-loss program to BCBSMA at the current $400,000 specific deductible. The award eliminates all lasers ($1.77 million of known catastrophic exposure), lowers the total cost of risk by approximately $1.23 million (34%), eliminates a $13,200 reporting fee, reduces the administrative fee by about 2.5% (approximately $51,000), speeds reimbursement, and adds renewal protections (no new lasers and a 50% renewal rate cap).

Financial Stability & Rate	Adjusted FY27 rates by 12.48% to reflect medical trend and actuarial analysis while rebuilding Trust reserves. The increase, voted in February 2026, was below the 16% previously projected.

Exhibit C: FY27 Plan Design Changes

Benefit (In-Network)	FY26	FY27
Annual Deductible (Individual / Family)	None	$250 / $500
Specialist Office Visit	$35	$60
Urgent Care	$35	$60
Inpatient Hospitalization (per admission)	$250	$500 after deductible
Outpatient / Day Surgery	$150	$250 after deductible
Emergency Room	$100	$100 (HMO: no deductible; PPO: after deductible)
Diagnostic X-Ray & Lab	Covered at 100%	No charge after deductible
Hi-Tech Imaging	$100	$100 after deductible
PCP Office Visit	$20	$20 (HMO: no deductible; PPO: after deductible)
Out-of-Pocket Maximum	Unchanged ($5,000 / $10,000)	
Prescription Deductible and Copays	Unchanged ($100 / $200; $10 / $30 / $65 retail)	

For the HMO, the deductible does not apply to office visits (including PCP, specialist, behavioral health, chiropractic and rehabilitation visits), emergency room visits, telehealth or urgent care; as with the GIC plans, office visits are not subject to the deductible. For the PPO, the deductible applies to all services except preventive care. The prescription deductible is separate from the medical deductible.

Exhibit D: Total Monthly Premium, Active Employees

Plan / Tier	FY26 (10/1/2025)	FY27 (7/1/2026)	Change
Network Blue New England HMO · Individual	$1,007.00	$1,133.00	12.48%
Network Blue New England HMO · Employee + 1	$2,344.00	$2,637.00	12.48%
Network Blue New England HMO · Family	$2,888.00	$3,248.00	12.48%
Blue Care Elect Preferred PPO · Individual	$1,180.00	$1,327.00	12.48%
Blue Care Elect Preferred PPO · Family	$3,221.00	$3,623.00	12.48%

Financial Position

$6,911,182
Trust ending balance, June 2026

Balanced
FY27 operating budget for the Trust

>$1M
Projected FY27 surplus (conservative estimate)

The Trust ended FY26 with a balance of $6,911,182, including approximately $500,000 set aside toward rebuilding its reserves. The Trust is no longer operating month to month financially. The FY27 rate adjustment, plan design changes, and pharmacy and stop-loss savings support a balanced FY27 operating budget and a projected surplus of more than $1 million, in line with the Trust's FY27 reserve target of $1 million and rebuilding the Trust's reserves to protect against unexpected claims activity and to recover from the financial losses experienced in FY26.

How HCGIT Is Rebuilding Its Reserves

Rebuilding the Trust's reserves has been the central goal of every action taken since the FY26 renewal cycle. Each step below either adds revenue, lowers the Trust's costs, or reduces its exposure to large claims, and together they are working toward the same result.

Action	Timing	How It Rebuilds Reserves
Mid-year rate adjustment	October 1, 2025	20% increase restored funding to cover claims for the remainder of FY26.
GLP-1s for weight loss removed	October 1, 2025	Removed a drug class that accounted for 30% of pharmacy spending while used by less than 3% of members.
New leadership	December 2025	Hilb Group appointed as Executive Director (consultant) to lead the financial turnaround.
Pharmacy coalition	FY27	Move to Employers Health with no change to the drug formulary; **$3.4 million** in projected savings.
Stop-loss award	FY27	Total cost of risk lowered by approximately **$1.23 million**; $1.77 million of lasered exposure eliminated; reporting and administrative fee savings of approximately $64,000.
Plan design changes	FY27	$250 / $500 deductible and modest copay increases, which together with the pharmacy changes reduced the projected FY27 increase from 16% to 12.48%.
FY27 rate adjustment	July 1, 2026	12.48% increase set to reflect medical trend and fund reserve rebuilding.
Operational efficiency	Ongoing	Competitive procurement of a benefits administration system; audits of claims and dependent eligibility.

~$500K
Set aside toward reserves at the end of FY26

$1M
FY27 reserve target, supported by a projected surplus of more than $1 million

~$4.6M
Projected FY27 pharmacy savings ($3.4M) plus lower stop-loss cost of risk ($1.23M)

The Trust is no longer operating month to month financially, and its reserve target for FY27 is $1 million. Going forward, the Trust will continue conservative rate setting so that reserves keep growing to a level that protects members against unexpected claims and avoids future mid-year increases.

Medicare Retirees

Retirees enrolled in Medicare Parts A and B are offered Medex 2 with Blue MedicareRx PDP, which renews on a calendar-year basis. For calendar year 2027, the funding rate will increase by 6.0%, from $495.00 to $525.00 per member per month, effective January 1, 2027. The rate was voted on October 14, 2026.

Exhibit E: Medex 2 with Blue MedicareRx PDP, Monthly Rate

Calendar Year	Monthly Rate (per member)	Change
2025	$416.00	15.6%
2026	$495.00	19.0%
2027	**$525.00**	**6.0%**

Federal Medicare changes taking effect in 2027, including higher Part B costs and a higher Part D out-of-pocket cap, are summarized in Section V. A comparison of Medex 2 with the GIC's Medicare plans is included in Appendix A.

IV. HCGIT Key Offerings

When comparing HCGIT's benefits and rates to other municipal market options, the Trust remains competitive following the FY27 renewal. Like many employers, the Trust continues to face sharp increases in healthcare costs and is taking the necessary steps to ensure financial stability for its members, including the pharmacy, plan design, and stop-loss actions described above.

A key value-add for member units is the level of individual unit support provided by the Trust's consultant. For FY27, HCGIT facilitated a number of education sessions for both member units and their employees on the plan design changes, supported by detailed communication materials. Because of the extent of this education, the adoption of the new deductible was achieved with minimal employee dissatisfaction. The Trust also provided collective bargaining support to individual units, along with supplemental materials to aid each unit's process.

Exhibit F: HCGIT Competitive Advantages

Key Highlight	Description
Cost-Effective Coverage	Offers competitively priced HMO and PPO plans with a $250 / $500 deductible, half the deductible of the GIC benchmark plan. Provides a supplemental plan (Medex 2) alongside Blue MedicareRx PDP for comprehensive coverage tailored to Medicare-eligible retirees.
Wide Network Access	Provides access to extensive BCBSMA provider networks, now including in-network coverage for dependents living outside New England.
Pharmacy Savings	Coalition purchasing through Employers Health, plus the CanaRx and ElectRx savings programs for maintenance and specialty medications, which are not available through the GIC.
Comprehensive Benefits	Includes health, life, dental, disability, and long-term care insurance for employees and dependents.
Expert Management	Hilb Group, as the Trust's Executive Director, and the Trust's partnership with BCBSMA ensure efficient claims processing and administrative support.
Member Unit Support	Individual support for each member unit from the Trust's consultant, including education sessions and communication materials for units and their employees on plan design changes, and collective bargaining support with supplemental materials for each unit's process.
Member Voice in Plan Design	Member units vote on proposed benefit changes through the Insurance Advisory Committee, unlike the GIC, where plan design is set by its Commissioners.
Wellness Initiatives	Expanding preventive care programs to improve employee health and reduce long-term costs.

V. Healthcare Market Trends

Healthcare is experiencing sustained cost pressure, with medical trend currently estimated at 8% to 12% and pharmacy trend at 14% to 18%. These increases affect public- and private-sector employers alike, regardless of funding arrangement, and continue to outpace wages and general inflation.

The Massachusetts Market

Massachusetts family health insurance rates are among the highest in the United States, and nearly half of residents report difficulty affording care. Several dynamics specific to the state are driving affordability, spending, and access:

- **Consolidation:** Insurer consolidation is limiting market options for employers, while mergers and acquisitions among hospitals and provider groups are reducing competition and increasing pricing power in contract negotiations.

- **Health system strain:** Hospital operating costs, administrative expenses, and new MassHealth supplemental payments are driving up spending, and financial troubles at systems like Steward have raised concerns about hospital closures and access to care.
- **Workforce shortages:** Shortages of nurses, doctors, and administrative staff are limiting access to care and increasing labor costs.
- **Affordability:** Premiums and member cost-sharing are outpacing wages and salaries.

Key Drivers of Rising Healthcare Costs

Exhibit G: Cost Drivers

Driver	What Is Happening
Pharmaceutical Prices	Specialty drugs, high development costs, patent protections, and limited competition continue to push pharmacy spending above medical trend. In the first nine months of 2025, GLP-1 medications for weight loss accounted for 30% of the Trust's pharmacy spending while being used by less than 3% of its membership, illustrating how quickly a single drug class can reshape costs.
Chronic Disease Prevalence	A growing number of individuals with chronic conditions, such as diabetes, heart disease, and behavioral health conditions, increases utilization and the long-term cost of management and treatment.
Aging Population	An increasing number of older adults leads to higher demand for medical services and long-term care.
Advancements in Medical Technology	New treatments and diagnostic tools improve patient care but often come with high price tags.
Provider Consolidation	Mergers and acquisitions among healthcare providers reduce competition, allowing for increased pricing power and higher service charges.
Administrative Expenses	The complexity of the healthcare system, including billing and insurance-related costs, adds to the overall financial burden on providers and patients.
Preventive Care Underutilization	Lack of access to, or participation in, preventive health measures can result in higher costs due to later-stage disease treatment. This is why prevention and point solutions are a focus of the Trust's long-term strategy.

What This Means for HCGIT's Rate Setting

With medical trend estimated at 8% to 12% and pharmacy trend at 14% to 18%, the cost pressures facing the market are not expected to ease in the near term. The FY26 experience showed how quickly a single drug class or a rise in high-cost claims can deplete reserves in a self-funded pool. For these reasons, HCGIT will continue to take a conservative approach to rate setting:

- Setting rates that fully reflect projected medical and pharmacy trend, rather than minimizing short-term increases.
- Continuing to rebuild reserves to a level that protects the Trust against unexpected claims and avoids the need for mid-year rate adjustments.
- Monitoring claims and pharmacy experience closely throughout the year so emerging cost drivers are identified early.
- Maintaining stop-loss protection to limit the Trust's exposure to catastrophic claims.

Federal Medicare Trends for 2027

Several federal changes in 2027 will affect Medicare beneficiaries nationally. These are changes to the federal Medicare program and do not change the benefits of HCGIT's Medex 2 or Blue MedicareRx plans; how each one applies to HCGIT retirees is explained below the table.

Exhibit H: 2027 Federal Medicare Changes

Change	Details
Part B Premiums and Deductibles	The monthly Part B premium is projected to rise to $209.50, an increase of $6.60 from the prior year. The Part B deductible is expected to reach $292, up $9.
End of Part D Premium Subsidy	The federal government is ending a subsidy that had been reducing premiums for stand-alone Part D drug plans by an average of $16 per month.
Higher Part D Out-of-Pocket Cap	The annual out-of-pocket spending cap for Part D increases from $2,100 to $2,400.
Negotiated Drug Prices	Under the Inflation Reduction Act, CMS-negotiated prices take effect for additional high-cost medications, including drugs for breast cancer, GLP-1s, inhalers for asthma and COPD, Type 2 diabetes, and major depressive disorder.
Medicare GLP-1 Bridge	A temporary CMS pilot program, running July 1, 2026 through December 31, 2027, through which eligible Medicare Part D enrollees can obtain GLP-1 medications approved for weight loss (Wegovy, Zepbound and Foundayo) for a flat $50 per month. Eligibility requires a BMI of 35 or higher, or a BMI of 27 or higher with a qualifying condition such as heart disease or prediabetes. The program is run by CMS, separately from the member's drug plan.

What This Means for HCGIT Medicare Retirees

- **HCGIT's drug plan:** Retirees' prescription coverage is provided through Blue MedicareRx (PDP), a group Medicare Part D plan sponsored by the Trust for its members. Its copays are set by the Trust's plan ($10 / $25 / $50 retail in 2026), not by the standard federal Part D design, and retirees do not pay a separate Part D premium; the cost is included in the Medex 2 rate of $525.00 per member per month.
- **Part B:** Medex 2 covers the Medicare Part B deductible in full.
- **Out-of-pocket cap:** Blue MedicareRx follows the federal Part D out-of-pocket cap ($2,100 in 2026), after which members pay nothing for covered Part D drugs.
- **GLP-1s for weight loss:** The Medicare GLP-1 Bridge is a federal program, not an HCGIT benefit. Based on published program guidance, members of employer group Part D plans are eligible, so qualifying HCGIT retirees may be able to access these medications through the Bridge; prescribers submit requests directly to CMS's central processor, and costs are not paid by the Trust's plan. Members should confirm eligibility with Blue MedicareRx Customer Care or their prescriber.

VI. Municipal Rate Trends

Massachusetts municipal employers saw more moderate, though still elevated, rate increases for FY27 following the historically high increases of FY26. Below is a five-year review of the Trust's rates compared to other joint purchasing groups, along with pertinent insurance market trends.

Exhibit I: Average Rate Renewal Five-Year Review

Fiscal Year	HCGIT Renewal	GIC Average	MIIA Average	Medical Trend*	Pharmacy Trend*
FY27	**12.48%**	**4.1%–13.6% (8.0% Avg)**	**2.9%–14.4% (8.3% Avg)**	**8%–12%**	**14%–18%**
FY26	18%–20% + 20% Midyear	10%–17% (11.7% Avg)	10%–20% (14.8% Avg)	8%–10%	14%–18%
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%

**Medical and pharmacy trends differ among Massachusetts-specific health insurers, funding arrangements, and formularies. These ranges reflect average values.*

HCGIT's FY27 increase of 12.48% is above the GIC and MIIA averages, reflecting the need to rebuild reserves following FY26. It was, however, below the 16% previously projected, as a result of the new deductible and the pharmacy changes described in Section III.

Following the FY27 renewal, HCGIT remains competitive with the GIC's benchmark plan, Harvard Pilgrim Explorer, with half the deductible and a lower HMO individual premium, although some coverage tiers cost less at the GIC. Like HCGIT, the GIC has eliminated coverage of GLP-1 medications for weight loss, effective July 1, 2026. While Health New England, the GIC's regional HMO, has lower premiums, HNE typically does not see the highest enrollment among the GIC's menu of plan options for municipalities. A detailed comparison of plan design and rates, including Medicare plans, is provided in Appendix A: FY27 HCGIT & GIC Comparisons.

Even the largest purchasing groups, including the GIC, are not shielded from these market dynamics. Although the administrative structures of the GIC and HCGIT differ, for FY2027 the GIC identified an initial appropriation shortfall of $239.5 million due to unadopted plan design changes, the onboarding of four new municipalities, and underfunded retiree health benefit accounts, as reported in the minutes of the Group Insurance Commission's September 17, 2026 public meeting.

VII. Outlook: FY28 and Beyond

Health insurance costs remain a significant challenge for municipalities and employers across Massachusetts, regardless of their funding arrangements. Medical trend is currently estimated at 8% to 12% and pharmacy trend at 14% to 18%, depending on the insurance carrier, funding arrangement, and formulary.

The FY27 renewal moved the Trust from recovery toward stability: reserves are being rebuilt, the operating budget is balanced, and the pharmacy and stop-loss changes have lowered costs and reduced the Trust's exposure to catastrophic claims. Going forward, the focus shifts from short-term stability to long-term sustainability, with ongoing review of plan designs and claims costs for further savings.

The Trust is also focused on ensuring efficiency in its operations. As part of this effort, HCGIT is looking to procure a benefits administration system through a competitive procurement process.

The Trust will **continue to evaluate pharmacy options annually**, given how quickly the pharmacy market is changing, and will look to **employ prevention and point solutions** to better control claims costs.

HCGIT 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. With its stable risk pool and the actions taken this year, the Trust is well positioned for the years ahead. Collaboration among member units and staying informed about emerging trends will remain essential.

What This Means for HCGIT's Future

No employer is immune to the rising healthcare costs facing the market. In response to the FY26 crisis, HCGIT took decisive corrective action: new leadership, a pharmacy coalition that preserved the drug formulary, stronger stop-loss protection, the elimination of GLP-1 coverage for weight loss, and a modest deductible that aligns its plans with municipal benchmarks. Through these steps, the Trust has regained its financial footing. HCGIT will remain competitive and viable as long as the group stays vigilant and continues to make fiscally responsible decisions.

APPENDIX A

FY27 HCGIT & GIC Comparisons

Summary · HCGIT and GIC: FY27 Plan Comparison
A-1 · HCGIT vs. GIC Benchmark Plan (HP Explorer)
A-2 · HCGIT vs. Other GIC Plan Options (HNE & Access America)
A-3 · HCGIT Medex 2 & GIC Medicare Plans

HCGIT and GIC: FY27 Summary

Plan year July 1, 2026 – June 30, 2027

MEDICAL DEDUCTIBLE	HMO INDIVIDUAL PREMIUM	OUT-OF-POCKET MAX
$250 vs. $500	**$1,133 vs. $1,291**	**$5,000 / $10,000**
HCGIT vs. GIC HP Explorer (single)	HCGIT is $158 / month below Explorer	Same at HCGIT and GIC

For the July 1, 2026 – June 30, 2027 plan year, HCGIT and the Group Insurance Commission (GIC) offer broadly similar coverage. Both have a $5,000 / $10,000 out-of-pocket maximum and cover preventive care in full. The main differences are in how members share costs, in prescription coverage, and in premiums.

Plan design

HCGIT's new $250 / $500 deductible is half the $500 / $1,000 deductible on the GIC benchmark plan, Harvard Pilgrim Explorer. The deductible works similarly in both: under HCGIT's HMO and the GIC plans, office visits are not subject to the deductible, while lab and X-ray, high-tech imaging, inpatient and outpatient surgery services are. One difference favors HCGIT: the $100 emergency room copay is not subject to the deductible under HCGIT's HMO, while the GIC plans apply the deductible after the ER copay. HCGIT uses flat copays, while Explorer's copays depend on the provider's tier. Hospital stays are a flat $500 per admission under HCGIT, compared with $275 to $1,500 depending on tier under Explorer. GIC's urgent care copay is lower ($20 vs. $60). Explorer's specialist copays vary by tier and can be lower or higher than HCGIT's flat $60: $30 at Tier 1, $60 at Tier 2 and $75 at Tier 3.

Prescription drugs

Both use a three-tier copay structure ($10 / $30 / $65 retail; $25 / $75 / $165 mail order) with a $100 / $200 Rx deductible. However, formularies, drug tiers and coverage rules differ, so a member's cost for a given medication may not be the same under each plan. HCGIT members also have access to the CanaRx and ElectRx savings programs, which are not available through the GIC. Like HCGIT, the GIC has eliminated coverage of GLP-1 medications for weight loss, effective July 1, 2026.

Premiums

HCGIT rates rose 12.48% for FY27, while the GIC plans shown in this appendix rose 5% to 9%. Compared with Explorer, HCGIT's monthly premium is $158 lower for HMO individual coverage, $45 higher for HMO family, $36 higher for PPO individual and $420 higher for PPO family. Compared with Harvard Pilgrim Access America, GIC's national PPO, HCGIT is $378 lower for HMO individual, $126 lower for HMO family, $184 lower for PPO individual and $249 higher for PPO family. Health New England, GIC's regional HMO, is $231 lower than HCGIT's HMO for individual coverage and $1,078 lower for family, although HNE typically does not see the highest enrollment among the GIC's menu of plan options for municipalities.

Other HCGIT features

HCGIT offers an Employee + 1 tier, which GIC does not, and now covers dependents living outside New England under the Network Blue HMO. Governance also differs: HCGIT member units vote on proposed benefit changes through the Insurance Advisory Committee, while GIC plan design is set by its Commissioners without a direct say by each participating employer. Plan design can change in any year under both; the GIC typically procures its plans every five years, while HCGIT can procure more often when needed.

Medicare retirees

HCGIT's Medex 2 rate of $525.00 for 2027, voted October 14, 2026, is $20–$27 a month above GIC's Medicare supplement plans. GIC's rates renew July 1, so the two are not on the same timeline.

BOTTOM LINE

HCGIT's benefits are comparable to the GIC's, with a lower deductible and predictable flat copays; GIC copays are lower for some services and higher for others, depending on the provider tier. On premium, HCGIT is competitive with the GIC benchmark plan: $158 a month lower for HMO individual coverage and $36–$45 higher for PPO individual and HMO family, while the PPO family tier ($420 higher) and GIC's regional HNE plan cost less at GIC.

APPENDIX A · FY27 PLAN COMPARISONS

HCGIT vs. GIC Benchmark Plan

BCBSMA HMO & PPO vs. Harvard Pilgrim Explorer · July 1, 2026 – June 30, 2027

	HCGIT · BCBSMA Network Blue NE HMO $250 Deductible	HCGIT · BCBSMA Blue Care Elect PPO $250 Deductible	GIC · BENCHMARK HP Explorer POS New England only
PLAN DESIGN			
PCP Required / Gatekeeper	Yes	No	Yes
● Deductible Single / Family	$250 / $500 Waived for office visits, ER, telehealth & urgent care	$250 / $500 Applies to all services except preventive	$500 / $1,000 Waived for office visits
Non-Network Deductible	Not Covered	Combined with In-Network	$500 / $1,000 then 20% coinsurance
Out-of-Pocket Max Single / Family	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
Non-Network Out-of-Pocket Max	Not Covered	Combined with In-Network	$5,000 / $10,000
NETWORK BENEFITS · MEMBER RESPONSIBILITY			
Preventive Care	No Charge	No Charge	Most covered at 100%
PCP Office Visit	$20 Copay	$20 after Ded.	T1 $10 / T2 $20 / T3 $40
● Specialist Office Visit	$60 Copay	$60 after Ded.	T1 $30 / T2 $60 / T3 $75
Mental Health / Substance Use	$20 Copay	$20 after Ded.	$10 Copay
● Urgent Care	$60 Copay	$60 after Ded.	$20 Copay
Emergency Room Waived if admitted	$100 Copay	$100 after Ded.	$100 after Ded.
Diagnostic X-Ray & Lab	No Charge after Ded.	No Charge after Ded.	No Charge after Ded.
Hi-Tech Imaging CT / PET / MRI	$100 after Ded.	$100 after Ded.	$100 / Scan after Ded.
● Inpatient Hospitalization	$500 / Admission after Ded.	$500 / Admission after Ded.	T1 $275 / T2 $500 / T3 $1,500 per Admission, after Ded.
● Outpatient / Day Surgery	$250 after Ded.	$250 after Ded.	$150 Eye/GI freestanding $250 all other in MA · after Ded.
Fitness / Weight Loss Reimbursement	$150 / $150 per policy per calendar year	$150 / $150 per policy per calendar year	Fitness: $100 individual $200 family
PRESCRIPTION DRUGS · CVS CAREMARK			
Rx Deductible Separate from medical	$100 / $200	$100 / $200	$100 / $200
Rx Out-of-Pocket Max	Included in Medical OOP Max	Included in Medical OOP Max	Included in Medical OOP Max
Retail Rx 30-day, T1 / T2 / T3	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65
Mail Order Rx 90-day	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165

FY27 MONTHLY PREMIUM	HCGIT HMO	HCGIT PPO	GIC HP Explorer
Employee	**$1,133.00** $158.24 below Explorer	**$1,327.00** $35.76 above Explorer	**$1,291.24**
Employee + 1	**$2,637.00** No GIC equivalent tier	n/a	n/a
Family	**$3,248.00** $45.02 above Explorer	**$3,623.00** $420.02 above Explorer	**$3,202.98**

● HCGIT change for FY27

Total monthly premium; employee share depends on each unit's contribution split. HCGIT FY27 rates +12.48% over FY26. GIC rates are full cost incl. 0.25% admin fee; per the GIC guide, some services require both a copay and a deductible. HP Explorer is the benchmark plan under MGL c. 32B §§ 21–23. Explorer benefits per Harvard Pilgrim's 2027 GIC Member Guide (Explorer POS Summary of Benefits, 7/1/2026–6/30/2027). HCGIT benefits per BCBSMA Summaries of Benefits.

HCGIT vs. Other GIC Plan Options

HCGIT BCBSMA HMO & PPO vs. Health New England & Harvard Pilgrim Access America · July 1, 2026 – June 30, 2027

	HCGIT · BCBSMA Network Blue NE HMO $250 Deductible	HCGIT · BCBSMA Blue Care Elect PPO $250 Deductible	GIC · REGIONAL Health New England HMO · Western MA	GIC · NATIONAL HP Access America PPO · outside New England
PLAN DESIGN				
PCP Required / Gatekeeper	Yes	No	Yes	No
PCP Referral to Specialist	Yes	No	No	No
Deductible Single / Family	$250 / $500 Waived for office visits, ER, telehealth & urgent care	$250 / $500 All services except preventive	$400 / $800 Waived for office visits & urgent care	$500 / $1,000 Waived for office visits
Out-of-Pocket Max Single / Family	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
NETWORK BENEFITS · MEMBER RESPONSIBILITY				
Preventive Care	No Charge	No Charge	Most covered at 100%	Most covered at 100%
PCP Office Visit	$20 Copay	$20 after Ded.	$20 / Visit	$20 / Visit
Specialist Office Visit	$60 Copay	$60 after Ded.	T1 $30 / T2 $60 no Tier 3	$45 / Visit no tiering
Behavioral Health / Substance Use	$20 Copay	$20 after Ded.	$20 / Visit	$20 / Visit
Retail Clinic & Urgent Care	$60 Copay	$60 after Ded.	$20 / Visit	$20 / Visit
Emergency Room Waived if admitted	$100 Copay	$100 after Ded.	$100 after Ded.	$100 after Ded.
Hi-Tech Imaging	$100 after Ded.	$100 after Ded.	$100 / Scan after Ded.	$100 / Scan after Ded.
Inpatient Hospitalization	$500 / Admission after Ded.	$500 / Admission after Ded.	$275 / Admission after Ded.	$275 / Admission after Ded.
Outpatient Surgery	$250 after Ded.	$250 after Ded.	$150 Eye/GI freestanding $250 hospital outpatient · after Ded.	$150 Eye/GI freestanding $250 all other · after Ded.
PRESCRIPTION DRUGS · CVS CAREMARK				
Rx Deductible Separate from medical	$100 / $200	$100 / $200	$100 / $200	$100 / $200
Rx Out-of-Pocket Max	Included in Medical OOP Max	Included in Medical OOP Max	Included in Medical OOP Max	Included in Medical OOP Max
Retail Rx 30-day, T1 / T2 / T3	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65
Mail Order Rx 90-day	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165

FY27 MONTHLY PREMIUM	HCGIT HMO	HCGIT PPO	Health New England	HP Access America
Individual	**$1,133.00**	**$1,327.00**	**$902.23**	**$1,511.32**
Employee + 1	**$2,637.00**	n/a	n/a	n/a
Family	**$3,248.00**	**$3,623.00**	**$2,170.16**	**$3,373.67**

GIC plans shown are those reasonably assumed for migration of Active and non-Medicare Retirees, based on geography. Although HNE premiums are lower, HNE typically does not see the highest enrollment among the GIC's menu of plan options for municipalities. The GIC benchmark plan (HP Explorer) is compared on page A-1. Total monthly premium; member share depends on each unit's contribution split. GIC rates are full cost including the 0.25% administrative fee. Sources: BCBSMA Summaries of Benefits; GIC 2026–2027 Municipal Benefits Guide; Harvard Pilgrim 2027 GIC Member Guide (Access America); Health New England GIC Member Handbook (effective July 1, 2026).

Governance: HCGIT and the GIC

HCGIT member units have a direct voice in proposed benefit changes through the Insurance Advisory Committee, which votes on the Trust's plan design. Under the GIC, plan design is set by the Group Insurance Commission's Commissioners, and participating employers do not have a direct say in proposed benefit changes. Under both, plan design changes can happen in any given year. The GIC typically procures its health plans every five years, while HCGIT can initiate procurements more frequently when needed, as it did for FY27 with its health insurance Request for Proposal and its move to the Employers Health pharmacy coalition.

HCGIT Medex 2 & GIC Medicare Plans

For retirees enrolled in Medicare Parts A & B

HCGIT MEDEX 2 W/ BLUE MEDICARE RX PDP

$525.00

per member per month · effective January 1, 2027

Voted October 14, 2026

CY2027 INCREASE

+6.0%

from $495.00

CY2026 RATE

$495.00

+19.0% over CY2025

CY2025 RATE

$416.00

+15.6% over CY2024

HCGIT Medex 2 vs. GIC Medicare Supplement Plans

	HCGIT Medex 2 w/ Blue MedicareRx Medicare Supplement + PDP	GIC HP Medicare Enhance Medicare Supplement	GIC HNE Medicare Supp. Plus Medicare Supplement	GIC Wellpoint Medicare Ext. Medicare Supplement
MONTHLY RATE				
Per Person Full cost	**$525.00** CY2027 (1/1/2027)	**$503.50** FY27 (7/1/2026)	**$505.44** FY27 (7/1/2026)	**$497.71** FY27 (7/1/2026)
Medex 2 Difference	—	+$21.50	+$19.56	+$27.29
MEDICAL BENEFITS · MEMBER RESPONSIBILITY				
Geographic Eligibility	**National**	National	National	National
PCP / Referrals Required	**No**	No	No	No
Deductible	**None** Medicare Part A & B deductibles covered in full	None	None	None
Preventive Care	**No cost** Medicare-covered services	No Copay	No Copay	No Copay
Physician Office Visit	**Covered in full**	$15	$15	$10
Outpatient Behavioral Health	**Covered in full** no visit maximum	$15	$15	First 4 visits $0 then $10 / visit
Inpatient Hospital	**Covered in full** +365 lifetime days after Medicare	No Copay	No Copay	No Copay in MA & Medicare providers
Diagnostic Lab & X-Ray	**Covered in full**	No Copay	No Copay	No Copay
Emergency Services GIC: waived if admitted	**Covered in full**	$50	$50	$50
Hearing Aids	**Not covered**	$1,700 per ear per 2 years	$1,700 per ear per 2 years	$1,700 per ear per 2 years
Fitness / Weight Loss Reimbursement	**$150 / $150 per year**	—	—	—
PRESCRIPTION DRUGS · HCGIT: BLUE MEDICARERX PDP · GIC: CVS SILVERSCRIPT EGWP				
Retail Rx 30-day, T1 / T2 / T3	**$10 / $25 / $50**	$10 / $30 / $65	$10 / $30 / $65	$10 / $30 / $65
Mail Order Rx 90-day	**$20 / $50 / $110**	$25 / $75 / $165	$25 / $75 / $165	$25 / $75 / $165
Rx Out-of-Pocket Cap	**$2,100 (2026)** then $0 for covered drugs	—	—	—

HCGIT Medex 2 renews on a calendar year (January 1); GIC Medicare plans renew July 1. Differences compare HCGIT's CY2027 rate with GIC's FY27 rate. Medex 2 pays the Medicare Part A and B deductibles and coinsurance in full. "—" = not stated in the source document. Sources: 2026 Medex 2 and Blue MedicareRx PDP Summaries of Benefits; GIC 2026–2027 Municipal Benefits Guide; HCGIT rate schedule.

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.
Formulary	Pharmacy	The list of prescription drugs covered by a plan, organized into tiers that determine the member's copay.
Health Maintenance Organization (HMO)	Plan type	A type of health insurance plan that limits coverage to a network of providers and requires members to elect a primary care physician (PCP). HMOs are a type of managed care organization, focused on controlling costs and coordinating care, with a network of 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 in-network providers. PPOs provide some coverage for out-of-network providers, but usually at a higher cost.
Point of Service (POS)	Plan type	A type of health insurance that combines features of HMOs and PPOs, offering 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, often paired with a health savings account (HSA). For 2026, the IRS defines the minimum deductible as $1,700 for an individual and $3,400 for a family.
Fully Insured	Funding arrangement	A group health plan in which the employer purchases insurance from a commercial insurer, 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.
Self-Insured (self-funded)	Funding arrangement	A group health plan in which the employer directly assumes the financial risk and pays medical claims rather than an insurance company. Self-funding offers potential cost savings and flexibility in plan design, but employers bear the full financial risk of 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.
Stop-Loss Insurance	Self-insurance	A policy that protects self-insured employers from catastrophic claims. Specific stop-loss reimburses claims for an individual member above a set deductible (for HCGIT, $400,000). A "laser" is a higher deductible set for a specific member with known high-cost claims.
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 representing the average cost or revenue associated with each member over a month, calculated by dividing total costs or revenues by the number of members.
Pharmacy Benefit Manager (PBM)	Pharmacy	An intermediary that manages prescription drug benefits for health insurers and employers by negotiating prices with drug manufacturers, creating formularies, and processing claims.
Medicare Part D	Medicare	The federal Medicare prescription drug program. Part D coverage is provided through private plans approved by Medicare, including individual plans and employer group plans; federal rules set minimum standards, while each plan sets its own copays and formulary.
Prescription Drug Plan (PDP)	Medicare	A stand-alone plan that provides Medicare Part D drug coverage. HCGIT retirees receive drug coverage through Blue MedicareRx (PDP), a group plan sponsored by the Trust with its own copays and formulary.
Medicare Supplement (Medex 2)	Medicare	A plan that pays costs Original Medicare (Parts A and B) does not, such as deductibles and coinsurance. HCGIT's Medex 2 covers the Medicare Part A and B deductibles and coinsurance in full.

Purchasing Coalition	Pharmacy	A group of employers that combine their purchasing power to negotiate stronger pricing, rebates, and contract terms with a PBM (e.g., Employers Health).

Outlook

Will rural schools receive their fair share?

From Corwin, Jessica <jessica.corwin@frsu38.org>

Date Tue 10/13/2026 8:01 AM

To townadmin@ashfield.org <townadmin@ashfield.org>; jlivingston@town.buckland.ma.us <jlivingston@town.buckland.ma.us>; cphillips@town.buckland.ma.us <cphillips@town.buckland.ma.us>; lwells@town.buckland.ma.us <lwells@town.buckland.ma.us>; selectboard@charlemont-ma.us <selectboard@charlemont-ma.us>; administrator@townofcharlemont.org <administrator@townofcharlemont.org>; bos@colrain-ma.gov <bos@colrain-ma.gov>; info@townofhawley.com <info@townofhawley.com>; Robyn Provost <Robyn@townofheath.org>; Elissa Viarengo <ElissaV@townofheath.org>; Will Emmet <Wemmet@townofheath.org>; BOS <towncoordinator@townofheath.org>; selectboard@town.plainfield.ma.us <selectboard@town.plainfield.ma.us>; Andrewbaker1959@gmail.com <Andrewbaker1959@gmail.com>; McBride413@yahoo.com <McBride413@yahoo.com>; Rick@lapierre.com <Rick@lapierre.com>; townadmin@townofshelburnema.gov <townadmin@townofshelburnema.gov>

You don't often get email from jessica.corwin@frsu38.org. Learn why this is important

Dear Mohawk Trail colleagues,

In January, the Massachusetts Foundation Budget Review Commission is expected to begin work to review the state's K-12 school funding formulas and make recommendations for future improvements. The Commission is required to hold at least four public hearings across the state, which represent a critical, can't-miss opportunity for rural school districts to share their stories about how chronic underfunding is affecting our districts. Rural students and communities have been left behind for decades, and this is our best opportunity yet to push equitable rural school funding to the forefront of the discussion.

We are reaching out to you to request your collaboration in the **Rural Schools Storyboard Project**. The Project is designed to help ensure that rural needs are front and center among the many voices that will be competing to influence future education funding formulas. A coordinated effort will be essential to maximize our message and our impact on the Commission. All stakeholders from rural school districts are encouraged to participate in the Project: Superintendents, School Committee members, Selectboard members, Finance Committee members, Town Meeting members, teachers, staff, students, parents, taxpayers, and more.

Participants will be asked to share their local stories with the Storyboard Project in writing or another form by December 18th. We will take these anecdotes and organize them into

cohesive media including a public website and a printed booklet for the members of the FBRC, highlighting common themes and narratives, and showcasing the alarming frequency and severity of struggle. (There should be a LOT of statements included. Repetition is expected. If the booklet is substantial enough to become a book, great.) We will also offer support to participants to parlay your stories into effective testimony for the Commission, and communicate and coordinate with participants to ensure that there will be as much rural testimony as possible at all hearings.

How you can help:

1. Sign up to join the Storyboard Project here. If you are unsure whether you will be able to participate, fill it out now and decide later. You can unsubscribe at any time.
2. Forward this message to other members of your community who may be interested in participating: principals, union leaders, PTOs, Town Administrators, Finance Committees, leaders of other town departments that have struggled due to budget shortfalls, parent advocates, high school student clubs, etc.
3. If you would like to join our organizing team and assist with planning, communications, editing, website and graphic design, etc., please email us!

We are stronger together, and we can't miss this opportunity. Giving our best effort to this rare chance for funding reform is one of the best possible uses of our time as district leaders. Thank you for engaging with us– we look forward to collaborating with you.

Your colleagues,

Martha Thurber, Chair, Mohawk Trail Regional School Committee
Jessica Corwin, Frontier Regional and Sunderland School Committees
Co-Chairs, MASC Rural Schools Committee

mthurber@mtrsd.org
jessica.corwin@frsu38.org
call/text Jessica: 413-773-0573

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Jessica Corwin
Chair, Sunderland School Committee
Co-Chair, Rural Schools Committee, Massachusetts Association of School Committees (MASC)
Secretary, Frontier Regional School Committee

NOTICE

All electronic Messages sent from Frontier Regional and Union #38 School Districts are archived in conformance with Massachusetts and federal Public Records law.