

Health Insurance Costs and Policy Choices Facing the City of Boston

After years of relatively stable health insurance premiums, the City of Boston may have to increase health insurance premiums by 22.6% in FY27. What factors contributed to this increase? How does the City manage health insurance revenues and health care expenses for city employees? What are the long-term policy options to sustainably stabilize premiums?

Report Objectives

This report provides information and insights on:

- State of Massachusetts' Health Care Spending
- Boston's Self-Insured Health Insurance: Advantages and Disadvantages
- History of Boston's Health Care Costs
- Policy Considerations for Managing Health Care Expenses and Revenues

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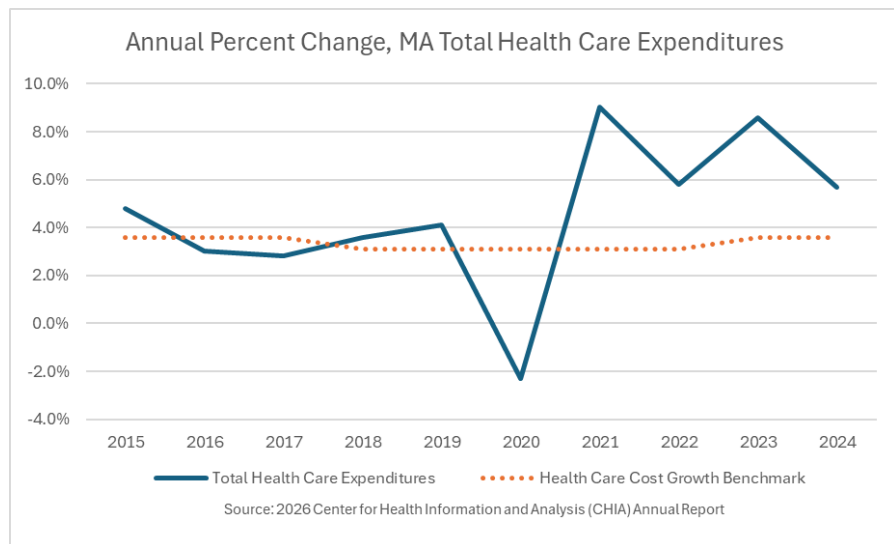
Boston’s Challenge

On February 26th of this year, Boston’s Chief Financial Officer informed the Boston City Council that, without urgent changes to current health insurance plans, the City will have to raise employees’ premiums at a record year-over-year increase of 22.6%. While health care costs and insurance premiums are rising across the state, the City of Boston is facing a perfect storm of factors that are triggering the record-setting rise in premiums. That perfect storm consists of several elements. First, Boston employees and retirees receive care in high-cost settings. Second, the City of Boston acts as an insurer for nearly all of its health insurance plans, and, as such, is directly responsible for paying almost all employee and retiree health care benefits. Third, the City’s efforts to stabilize health insurance premiums depended on market assumptions that deviated substantially from actual revenues and expenses. In FY25, the surplus funds that had moderated premiums were exhausted. Finally, and crucially, Boston has few tools at its disposal to make plan changes to align projected health care expenses with revenues in response to specific unanticipated cost drivers, such as GLP-1 use. This *Special Report* explores these factors and more that present Boston with a unique challenge heading into the FY27 budget cycle.

Massachusetts’ Health Care Environment

Cost of Health Care – The Massachusetts Health Policy Commission (HPC), a state agency tasked with measuring and addressing health care cost trends within the state, set the benchmark of annual growth of health care expenditures per capita to be 3.6% from 2023 to 2026. However, the sharp 9.0% growth of health care expenditures from 2020 to 2021 well exceeded the benchmark, stemming from a decrease in service utilization during the COVID-19 pandemic. This was followed by further surges in health care expenditures at 5.8% growth in 2022, 8.6% in 2023, and 5.7% in 2024.

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Health care utilization was extremely low in 2020 due to the COVID-19 pandemic. As a result of this low base, health care spending increases from 2020 to 2021 were driven largely by a surge in utilization over this time. That shock notwithstanding, according to the HPC, rising cost for care, as opposed to higher utilization growth, has been the primary driver of overall growth in commercial health care spending from 2021 to 2023.

Massachusetts has long been the national leader in promoting residents' access to health care and health insurance coverage. In 2006, Massachusetts became the first state to adopt legislation aimed at providing health care coverage for nearly all state residents. As of 2023, Massachusetts had higher rates of hospital inpatient (7% higher) and outpatient (43% higher) visits than the national average. In 2024, Massachusetts had the lowest uninsured rate of any state at 2.8%, well below the United States' rates overall. Massachusetts' high health insurance coverage leads to positive outcomes such as protecting against catastrophic health care costs and encouraging uptake of preventative care.

Unfortunately, the cost of health insurance and health care services in Massachusetts are high and increasing. Per HPC estimates, Massachusetts had the second highest health insurance premiums in the country in 2023. Inpatient services represent a high-cost set of services and experienced 4.1% growth from 2022 to 2023. Spending on services provided in hospital outpatient departments, while less expensive, grew 8.3% from 2022 to 2023.

Potential drivers of hospital inpatient and outpatient cost increases include provider concentration and variation in costs for services across providers. Six hospital systems provided 71.3% of all inpatient care in the state in FY25. The 2025 HPC Cost Trend Report documented substantial price variation across providers offering the same standard basket of outpatient services in 2023. Provider practice patterns also varied significantly, with differing costs of health care services for patients associated with different networks. For example, per the aforementioned report, for a basket of services that could be performed in either an outpatient or office setting, patients attributable to Mass General Brigham (MGB) were treated in outpatient settings rather than office settings 74% of the time. The average outpatient visit for these services cost \$10,184 more per visit than an office visit, amounting to significant unnecessary spending among MGB patients.

Rising Pharmaceutical Costs – In Massachusetts, according to the HPC, growth in prescription drug spending for all payers was the top driver of total health care spending from 2022 to 2023. A national survey of health plans by the Segal Group found that plans covering anti-obesity medications experienced 14.8% prescription drug utilization growth in 2024, whereas plans that did not cover GLP-1s had prescription drug utilization growth of 9.2%. Blue Cross Blue Shield estimated that, for their commercial plans at the state level, eliminating GLP-1s for anti-obesity would reduce premiums by 3 points of premium growth.

Boston has actively worked to constrain growing pharmaceutical costs for many years, but cost growth stemming from pharmaceuticals continues to be a significant challenge. Boston's decision to cover GLP-1s has caused significant cost increases for pharmaceutical coverage. [According to Chief Financial Officer Ashley Groffenberger](#), only 7.7% of non-Medicare plan members are utilizing GLP-1 drugs for weight loss through Boston's insurance, but this utilization will represent 14.7% of the projected cost growth from FY26 to FY27. The GLP-1 costs for Boston are expected to increase 50.0% year-over-year, rising \$15.8M from FY26 (\$31.6M) to FY27 (\$47.4M).

Boston's Health Care Context

Boston's Self-Insured Health Care Benefits – When formulating the operating budget, health care costs for the City of Boston include costs for health, dental, and life benefits for City employees

and retirees, as well as an appropriation for OPEB.¹ As of FY22, roughly 98% of the City’s health benefits were insured by the City (i.e. self-insured) and held in a separate fund established under M.G.L. c. 32B, § 3A.

For self-insured health care benefits, the City contracts with traditional commercial insurance companies (e.g. Blue Cross Blue Shield and Mass General Brigham Health Plan) to furnish employees with services, including provider networks and client services. Boston assumes all the financial risks, obligations, and responsibilities of a traditional commercial insurance company for operating health insurance, including setting premiums, determining plan design, and paying claims. Unlike traditional commercial health insurance plans, where premiums and plan design are housed within the insurance carrier, premiums and plan design decisions for Boston’s self-insured plans are bifurcated, with the City of Boston negotiating with union representatives of insured members to determine plan design and setting premiums based on actuaries’ guidance to meet its fiduciary obligations.

According to the City’s Annual Comprehensive Financial Report (ACFR), the City’s self-insured health care benefits are paid for by employees’ and the City’s contributions, and are held in its Internal Service Fund, the Health Claims Trust Fund (“the Fund”). Per FY24 ACFR, the Fund is governed by M.G.L. c. 32B, § 3A, follows generally accepted accounting principles (GAAP), and is managed by the City of Boston. According to the City of Boston Health Benefits

Office’s guidelines produced in 2011, employee and employer contributions are expected to fund reserves to cover claims incurred but not reported in the fiscal year, and a “catastrophic” reserve equaling between 5% to 15% of the fiscal year expenses to pay for higher than anticipated expenses, as well as expected outlays from claims. As noted in the City’s FY25 ACFR, Fund transactions are included in the City’s statement of activities, but moneys that go into the Fund are not considered general revenues. If contributions exceed claim outlays and the catastrophic reserve requirement in a given fiscal year, the Fund will have a surplus. Surpluses are held separately by the Fund.

Boston’s FY26 Health Plans

Per a Segal Group presentation to the Public Employee Committee (PEC) on January 1st, 2026, and City audit reports for FY25, the City self-insures the benefits covered by its MGB Value HMO, BCBS Standard HMO, and BCBS PPO plans. The City self-insures medical benefits and fully insures prescription benefits for HPHC Medicare Enhance and BCBS Medex. The City, with input from the PEC, selected Blue Cross Blue Shield (BCBS), Mass General Brigham, and Harvard Pilgrim Healthcare (HPHC) via a competitive procurement process to furnish self-insured services. Three plans—Tufts Medicare Preferred HMO, BCBS Managed Blue for Seniors, and BCBS Medicare HMO Blue—are fully-insured plans. The City pays premiums to BCBS, Tufts Medical and HPHC, which then assume all financial risk, management and provision of services under these plans.

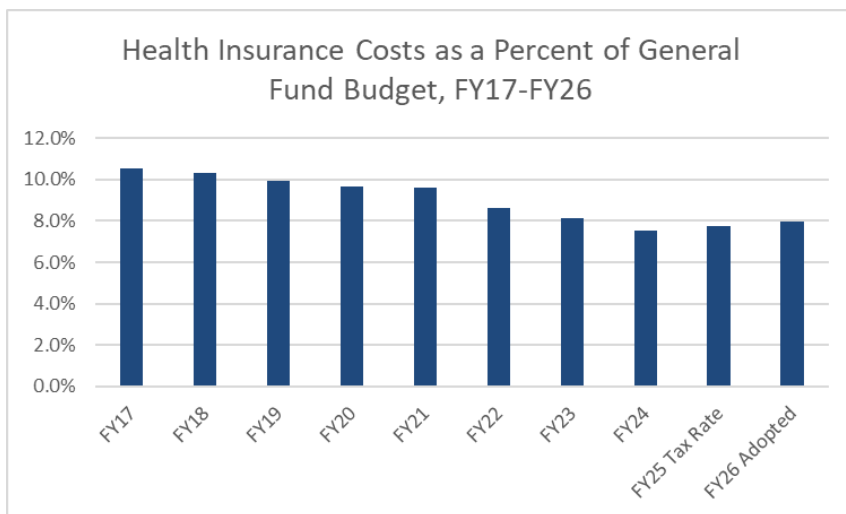
¹ Other Post-Employment Benefits (OPEB) refers to non-pension benefits that public employees receive after they retire, including health, life, and dental insurance. Per the most recent Actuarial Valuation from June 30, 2023, Boston’s OPEB unfunded actuarial accrued liability was \$2.68B. Every year since FY13, Boston has contributed \$40.0M to the OPEB Trust, which had assets of \$1.17B as of June 30, 2024. Unlike pensions, which face a state-mandated deadline of reaching full funding by 2040, OPEB liability does not face such a deadline, but is instead subject to reporting requirements. For the purposes of this report, the Research Bureau has treated OPEB as separate from its definition of health care costs.

Setting Premiums for Self-Insured Health Insurance Plans – The City of Boston commissions an actuarial study by a 3rd party (currently, the City uses the Segal Group) to forecast costs and set premium rates for the upcoming year. Per guidance produced by the Office of Health Benefits in 2011, there is no cap on how much premiums can rise from year-to-year. If the Fund holds a surplus, Boston’s policy is to use the surplus to subsidize expenses to stabilize increases in premiums over multiple years. If there are no surplus reserves and claims exceed revenues from premiums and the catastrophic reserve, actuaries advise the City to set premiums for the next fiscal year to pay for anticipated expenses for the upcoming fiscal year and to begin restoring the catastrophic reserve.

Premium increases are circumscribed by plan designs. Plan designs are dependent on collective bargaining negotiations with Boston’s Public Employee Committee (PEC), which serves as a bargaining representative for the City’s public employee bargaining units and retirees. Boston’s PEC was created in 2011 under M.G.L. c. 32B, §19. The current PEC contract was extended to be in effect until June 2027. The following plan design components are subject to PEC negotiations with the City: copays, deductibles, provider networks, premium splits, as well as pharmaceutical and medical service coverage.

City of Boston Health Insurance Cost History

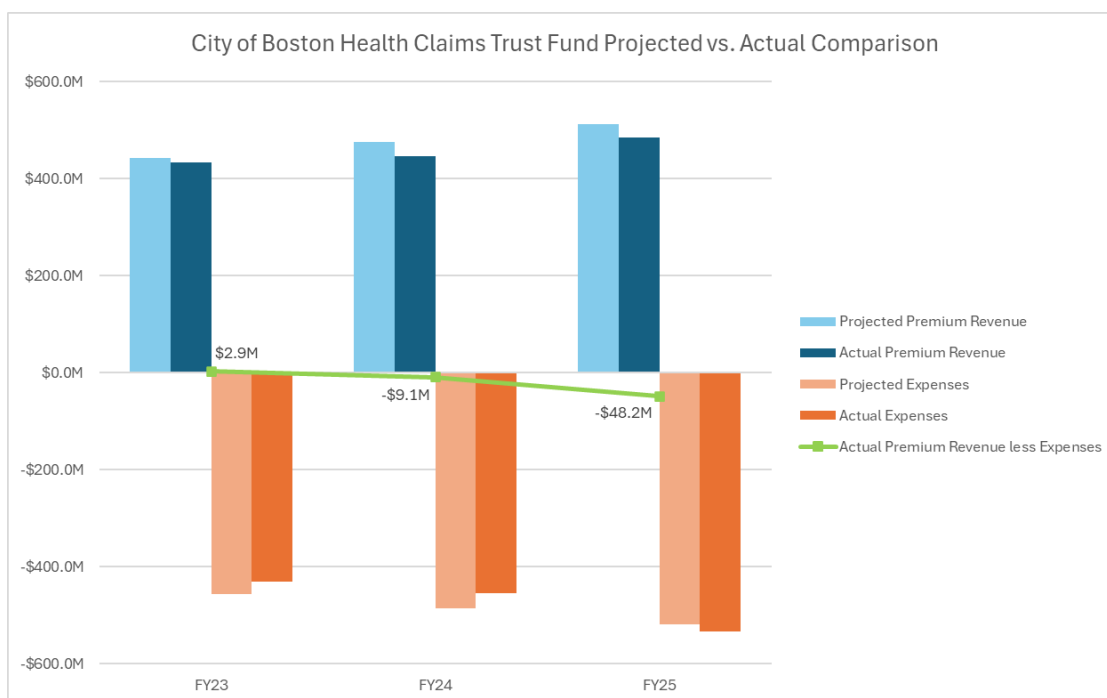
Health Insurance Costs in the General Budget – Health insurance is budgeted to cost Boston \$385.1M (8.0%) of the \$4.84B FY26 adopted general operating budget. \$133.8M is for health insurance for BPS employees, with \$251.3M budgeted for all other departments. Despite increased health insurance costs in recent years, health insurance costs for the City remain a smaller proportion of the budget than a decade ago. From FY17 to FY24, health insurance costs fell steadily from 10.5% of expenditures in FY17 to 7.5% in FY24. In FY25 and FY26 however, health insurance costs grew as a



share of the budget to 8.0% and are expected to do so again in the FY27 budget when it is released in April. With slower revenue growth expected in FY27, due in part to the [lowest level of new growth](#) in more than a decade, significant expected growth in health insurance expenditures is expected to make up a larger share of the upcoming budget.

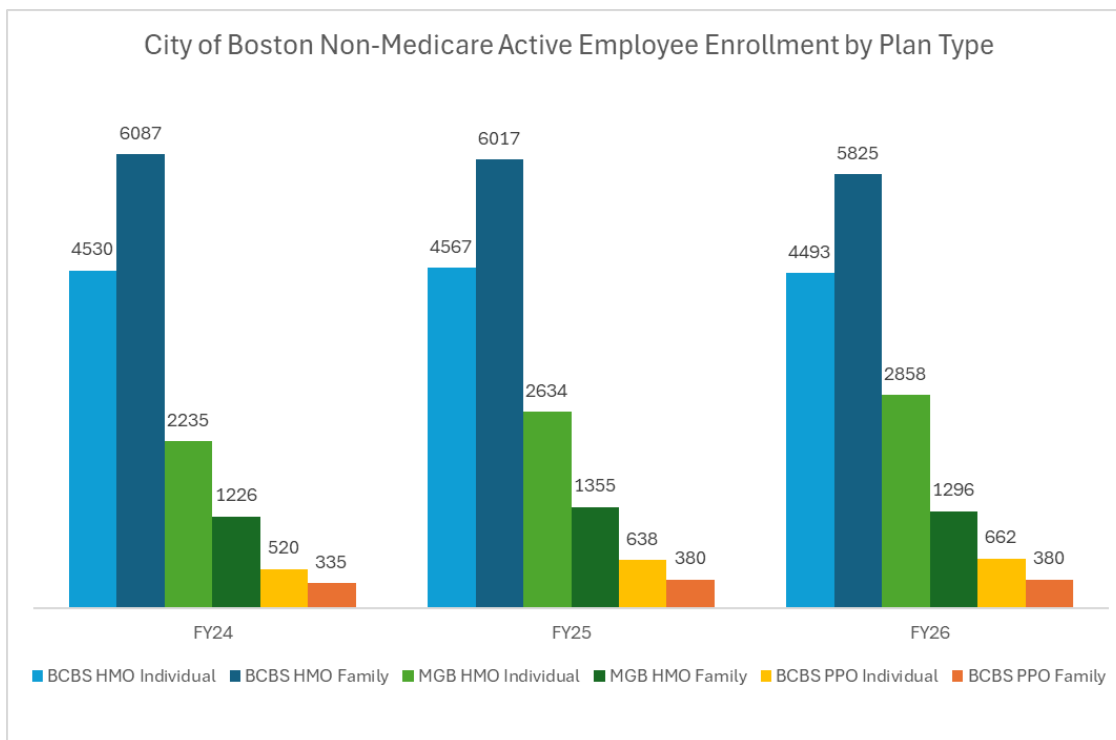
Stabilizing Premiums Increases – The City of Boston’s management of the Fund’s resources was responsible for the reduction in health insurance costs as a share of the general operating budget from FY17 to FY24. According to reports to the PEC, from FY12 to FY24 the Fund had a surplus reserve. In FY14, in line with the 2011 policy produced by the City of Boston Health Benefits Office, Boston contracted with the Segal Group to create a multi-year strategy that drew from the Fund’s

surpluses to set premiums lower than expected expenses and used the surplus to make up the difference. In FY22, the City requested the Segal Group revise its multi-year strategy in response to changes in expenses and revenues during the pandemic. The multi-year strategy was expected to extend through FY29. Aligned with an effort to avoid a one-year jump in premiums, the FY22 multi-year strategy did not prescribe drawing down the reserve consistently over time. Rather, it recommended a larger drawdown in FY23 with smaller surpluses available to make smaller reductions in premiums through FY29. The City of Boston and Segal annually review variances between projected and actual expenses and revenues from the previous year and adjust the strategy accordingly. Due to variances in expected versus actual revenues and expenses, the City adjusted the timeline for surplus exhaustion several times: in FY21, the City expected to exhaust the surplus in FY27; in FY22, the City projected the surplus to be exhausted in FY29; and in FY24, the City expected to exhaust the surplus in FY28.



Gap Between Projected and Actual Revenues – First, when comparing the Segal Group’s analysis presented to the PEC on February 8th 2022, against quarterly Fund reports presented to the PEC in 2023, 2024 and 2025, actual premium revenues were below the FY22 revenue projections for FY23, FY24 and FY25. While it is impossible to pinpoint a specific cause from the data available publicly, enrollment changes may have contributed to the differences in projected versus actual revenues for these years. According to a City of Boston presentation to the PEC, from FY24 to FY25, overall enrollment in City non-Medicare health plans increased by 658 or 4.4%. For the same time period, the MGB HMO plan, which has the lowest premiums, gained 528 enrollees (families and individuals).

Gap Between Projected and Actual Expenses – Second, per the Segal Group analysis presented to the PEC on February 8th 2022, the City’s strategy relied on a relatively stable estimate of 7% expense growth to calculate the surplus subsidy and premium increases. In FY23 and FY24, actual expenses were less than projected and grew by 5.8%. In contrast, in FY25 actual expenses were higher than estimates. Moreover, the Fund saw a 17.3% increase in expenses from FY24 to FY25.



Restoring the Catastrophic Reserve – Importantly, this surge in total expenses in FY25 occurred in a year when the surplus had already been diminished due to premium subsidization in FY23 and FY24. In addition to exhausting the surplus, the City had to use its catastrophic reserve to cover outlays in FY25. In order to comply with the reserve requirements, the City must restore the catastrophic reserve. Because expenses surged without significant changes in plan design, the catastrophic reserve amount that premiums must cover in FY27 is larger than in prior fiscal years. Even with a gradual replenishment of the catastrophic reserves, this will put upward pressure on premiums in FY27.

Potential Options for the City

Moving forward, given the City’s experience with volatile claims as well as its policy to spend-down surpluses to stabilize premiums, the Research Bureau recommends the City reconsider how it structures its spend down of surplus funds to stabilize premiums. Given the historical performance of the Fund, it is possible that it will hold surpluses again. If the City decides to use surpluses to subsidize premiums in the future, it may benefit from increasing its catastrophic reserve rate by some fraction of expenses that it subsidizes with the surplus to further mitigate the possibility of a premium shock.

As noted earlier, plan design drives premiums. To be sure, Boston employees have taken on higher cost shares and changes in benefits in the current PEC agreement to save money and constrain health care costs. Notably, on March 25th, the City and PEC [reached an agreement](#) to restrict GLP-1 use in the face of the impacts that GLP-1 utilization had on the expenses. While this action will lower expenses, it will not halt persistently rising costs. To address this, the City may need to conform to commercial plans more closely in the years ahead. For example, in the most recent HPC report on cost trends, Blue Cross Blue Shield commercial plans had the lowest costs for hospital outpatient services compared to other payers in Massachusetts; unfortunately, Boston's BCBS plan costs were higher than the BCBS commercial plan costs in both these categories.

In their 2011 analysis of reserve requirements for the Fund, the Segal Group identified Boston's exposure to unexpected high claims from individual participants as a risk to the Fund's financial position. One option available to the City is to purchase stop-loss coverage against this exposure. The Segal Group noted that the City's pool of members and size of catastrophic reserve mitigated the severity of this risk, and the City did not purchase stop-loss coverage. Both Blue Cross Blue Shield and Mass General Brigham flagged for the PEC that high-cost claimants were disproportionately driving spending increases in their plans in presentations in FY23 and FY25. In Blue Cross Blue Shield's presentation to the PEC, they noted that in 2023, 15% of its plan subscribers accounted for 34% of member expenditures in FY23. Similarly, high-cost claimants in the MGB HMO plan, which numbered 9.6 to every 1,000 members, accounted for a quarter (25.3%) of spending in FY24.

As the Chief Financial Officer [noted in her letter](#) to the City Council on March 16th, the City of Boston may need to revisit whether to retain control over plan design and negotiate plan design with Boston's unions under M.G.L. c. 32B, §19 or join the state's Group Insurance Commission under M.G.L. c. 32B, §21 and §23. These provisions allow cities and towns to include potential plan design changes to copayments, deductibles, tiered provider network copayments, and other cost-sharing features up to the dollar amounts of those same or similar features in the most enrolled GIC plan. However, because most Boston employees and retirees enroll in Blue Cross Blue Shield, moving to the GIC would create a tangible disruption for employees in terms of the provider networks and preferred health care service sites.

In the immediate term, the City of Boston must make tough choices on how to pay anticipated expenses and restore the Fund's catastrophic reserve. A fundamental decision confronting policymakers is whether overruns for health care for City employees should be covered with funds that would otherwise go to city services. The City of Boston must fulfill its obligations to provide employees with access to health insurance; but it needs to be mindful that funding for health care, particularly at current rates of increase, takes funding from other programs that benefit Boston's residents.