MERGED MARKET RATE FILING SUMMARY
(211 CMR 66.08(3)(c))

OVERVIEW OF THE FILING

Name of Company: …… Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.

Actuary Responsible for Filing: ……..Andrew Lafortune, F.S.A., M.A.A.A.

Coverage Period for Rates Filed: ……	issued/renewed in CY 2025
Number of Plans Filed: ……	47
Number of Renewing Individuals and Dependents: ……	21,309
Number of Renewing Small Groups: ……..	17,022
Number of Renewing Small Group Members: ……	150,339
Overall Average Proposed Rate Change over Prior Period: ……	6.7%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

Premium rates reflect the actual cost of medical care for our members.

- All health plans are required by state and federal law to spend a percentage of the revenue they receive in premiums on the care of their members (versus on administrative costs or for reserves/surplus). In Massachusetts, we have the most rigorous requirements in the nation, whereby at least 88 cents of every premium dollar must be spent on our members' care. Over the past 9 years, BCBSMA has delivered an average of 89 cents of our merged market premium dollar to our members' care.
- As recent state reports have found, hospital and pharmaceutical costs continue to be the two largest categories of medical spending increases across Massachusetts. More than half of total medical expense trend is driven by increases in provider reimbursements. The effects of inflation and labor shortages have led to large price increase requests from healthcare providers. Additionally, more than 25% of total medical expense trend is driven by pharmaceutical costs. The impact of blockbuster high-cost biologics, GLP-1 weight loss drugs, and other innovative emerging therapies has a material impact on current trend. These dynamics put added pressure on medical claims, which in turn causes premiums to increase.
- There are several other factors that drive medical spending, including the use of inpatient and outpatient services, an aging population, and the increased cost of prescription medications (especially specialty drugs).

- We remain committed to keeping premiums as low as possible in a highly competitive marketplace while investing in new technology and services to deliver an even better experience for our members. We are working tirelessly in partnership with hospitals and physicians across the state to moderate the growth in health care costs and make quality care accessible for all.

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying file(s) called "Plan and Benefit Templates."

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

Provider reimbursement under our fully insured managed care (HMO and POS) networks includes fee-for-service, incentive, risk-sharing, and capitated arrangements. Our capitated contracts are limited to a small number of organized groups of physicians. The organized groups reimburse their individual physicians according to the contracts between those parties. There are no capitation arrangements applicable to our PPO product.

Physicians who enter into our Value-Based Contract payment models agree to take responsibility for the full continuum of care received by their patients. These physicians have the opportunity to earn financial incentives if they perform well on specific measures that we select for their importance to our members and providers.

We make annual adjustments to our provider reimbursements based on shifts in our underlying fee schedules, adjustments based on provider performance through incentive programs, as well as in accordance with contractual commitments. The development of our base schedule comprises of CMS resource-based relative value scale (RBRVS), CMS fee schedule, Gap filled RVU, Local Medicare Admin Contractor and/or plan IC (individual consideration). Apart from incentive-based differences in reimbursement, providers may be paid differently based on network need, which takes into account a number of factors such as geography and the types of services provided.

We are currently not considering any major reimbursement methodology changes.

SUMMARY OF ADMINISTRATIVE EXPENSES

See accompanying file called "Exhibit for Public Release."

MEDICAL LOSS RATIOS

See accompanying file called "Exhibit for Public Release."

CONTRIBUTION TO SURPLUS

The contribution-to-surplus for all products in this filing is 1.9%, which is consistent with the statutory threshold. This feature ensures a balanced and stable market, enabling our members to rely on BCBSMA's continuing ability to provide uninterrupted coverage for their healthcare needs.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

The primary differences between historical actual fee for service (FFS) claims outlined in this filing and FFS claims reported in financial statements are as follows:

- Timing differences
    - Base period – Financial statement reporting period is on a calendar year basis whereas FFS claims in this filing is not, in order to reflect most recent available data
    - Incurred vs. Paid differences – Financial statements are reported on a point-in-time paid basis whereas the rate filing information is on a point-in-time incurred basis
- Items that are categorized differently in financial statements versus rate filings:
    - Cash Settlements such as fraud or provider dispute settlements
    - Provider Bad Debt Write-offs
    - Non-Massachusetts State Government Assessments
    - Access Fees or fees paid to other Blue Cross plans for administration of BCBSMA membership

COST CONTAINMENT PROGRAMS

Our cost containment programs are integral to the delivery of high-value and affordable health care. These programs are evaluated and measured on a constant basis. We conduct an annual financial measurement of our Care Management programs at a book of business level. Estimated savings associated with these results are derived using both pre/post as well as intervention vs. control methodologies in order to review and report on overall financial performance of our programs.

A. Health Management

1) Utilization Management

The BCBSMA Utilization Management area is staffed by physicians, registered nurses, physical therapists, occupational therapists, LICSW's and case management registrars. The Telephonic Clinical Review Unit is dedicated to ensuring members receive cost effective, appropriate and coordinated care. The team reviews clinical requests for services to determine appropriate level of care, site of service and length of stay for inpatient hospital, skilled nursing facility, long term acute care facility, and acute rehabilitation hospital admissions. The UM team also reviews all outpatient services that require authorization related to home care, outpatient therapy, and BCBSMA services that have associated medical policies. The clinical review unit refers members to case management and facilitates discharge planning for high-risk members.

2) Care Management

Our member-centric Care Management programs promote quality, cost-effective care through collaborative partnerships with providers and direct member engagement of their health issues. The program:

- Improves the member's health status and quality of life;
- lowers rates of complications and potentially avoid emergency room visits, inpatient admissions, and readmissions; and

- Serve as a bridge to community resources and comprehensive use of benefits

3) Prevention
BCBSMA manages a breadth of preventative programs including issuing cancer screening reminders as well as chronic condition management assistance. We reach our members directly and through a wide variety of modalities, including text messages, phone calls, letters, and emails. This is instrumental in improving our member's health while containing long term care costs.

4) Wellness
BCBSMA manages a breadth of wellness programs to improve our member's health and contain long term health care costs. While there are too many to detail here, health assessment programs and tools, referrals to health-specific evidenced-based interventions, and consultative services to employer groups to develop comprehensive wellness programs addressing high-cost health problems are important wellness programs that are currently benefiting members.

B. Payment Integrity – BCBSMA conducts a number of activities to ensure accurate and appropriate payment of claims. BCBSMA ensures claims are processed with accuracy, efficiency, and effectiveness through a multitiered approach. Claims are processed using cost-containment policies and practices that prevent duplicate payments, billing abuse, and fraud. We focus on three key areas of process: cost avoidance, pre-payment, and post-payment—ensuring each one connects seamlessly to the next. These activities are detailed and, as an example, include using an up-front claim editing software to assure claims are paid according to BCBSMA's payment policy, and identifying cases of provider and member fraud, waste, and abuse to prevent losses and improve processes of managing claims.

C. Pharmacy Management
Blue Cross has implemented a number of strategies to control prescription drug cost and utilization (at no additional charge to the account). Strategies include:

- Clinical management programs, such as prior authorization (on both the retail and medical benefit), step therapy, quality care dosing, and formulary management.
- Academic Detailing Program. The program identifies high cost drugs, that have lower cost alternatives, such as drugs dispensed as brand that have generics, etc, and communicates opportunities with providers. Communications are sent via electronic facsimile.
- Mandatory Specialty Pharmacy network, which offers deeper discounts on specialty medications, and value-added services, such as member education and a 24-hour nurse line.
- Provider education on our formulary and policies via newsletters, academic detailing and eRx messaging.
- Safety initiatives such as Drug Utilization Review (DUR, both Concurrent and Retrospective).

- Generic promotion programs, including generic substitution at mail.
- Mail Service Pharmacy promotion programs, including:
    - Mail Service Education
    - Mandatory Mail: Members filling chronic, maintenance medications at retail are allowed two fills and are then mandated to use the mail service pharmacy. This is an optional rider for accounts that are self-insured only with all plan designs. We are no longer actively marketing this product for ASC given the availability of the Retail 90 products.
    - CVS Retail 90: Accounts receive the same discounts at both mail and the CVS retail location

Blue Cross also has certain plan features such as ancillary fees on multi-source brand medications, no cost generic medications, zero cost share on select generic and preferred brand medications for: depression, diabetes, hyperlipidemia, heart and hypertension, and depression.

D. Merged Market Cost Containment Initiatives

BCBSMA protects our customers from costs of potential enrollment misrepresentation and fraud and ensures it is covering individuals eligible for non-group coverage in Massachusetts. As examples of these many varied activities, we note:

- Front-end gate keeping: new business non-group applicants are asked to verify eligibility prior to enrollment; and
- Residency Investigations: By employing a systematic process, BCBSMA identifies individuals that have potentially misrepresented Massachusetts residency to obtain coverage or have moved out of Massachusetts, and thus are ineligible for non-group coverage in the state.

E. Provider Reimbursement and Incentive Systems

Blue Cross continually seeks to improve the quality of care our members receive through performance-based incentive contracts with network providers. We periodically renew our provider agreements in a manner to sustain our robust network and maintain this focus on high quality affordable care. See General Methodology for Establishing Rates of Reimbursement section on page 2 of this summary for more details.