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

OVERVIEW OF THE FILING

- Company Legal Name: Boston Medical Center Health Plan, Inc. (BMCHP) d/b/a WellSense Health Plan (WellSense)
- Actuary Responsible for Filing: Blesilda Tuan, ASA MAAA
- Coverage Period for Rates Filed: Issued/renewed in CY 2026
- Number of Plans Filed: 8
- Number of Renewing Individuals and Dependents: 132,551
- Number of Renewing Small Groups: 375
- Number of Renewing Small Group Members: 861
- Overall Average Proposed Rate Change over Prior Period: 16.2%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

The overall average annual premium rate change is 16.2%, which is driven by the factors outlined below:

- Projected higher medical and pharmacy trend:
    - We are observing a sustained upward cost trend in medical services. During provider contracting negotiations, the providers tend to demand higher rate increases for our ACA line of business to compensate for the lower Medicaid reimbursement rates on our Medicaid line of business.
    - Network re-contracting across all metal tiers, which was necessitated by requirements in the Connector's 2024 SOA, continues to contribute to the overall increase in provider costs. The discontinuation of the ConnectorCare pilot program would exacerbate the impact as members transition to Bronze plans, where we pay higher provider reimbursement rates.
    - The annual trend for behavioral services was near 30% during the past two years, driven by higher utilization from members redetermined from MassHealth and increasing provider cost trends. WellSense expects these trend pressures to continue, even as we insource behavioral health services for 2026.
    - Even with the exclusion of anti-obesity GLP-1 coverage, the pharmacy trend remains above double digits. This is largely due to a shift in utilization toward brand-name and specialty drugs, including some newly approved high-cost cell and gene therapies.

- Furthermore, we anticipate higher pent-up utilization driven by the significant membership growth WellSense has experienced since the beginning of 2024. Many of these new members were only partially enrolled during the base period and are expected to elevate their utilization to normal levels in the following years.

- Risk Adjustment: WellSense has experienced over a 20% average annual increase in risk adjustment transfer payment PMPMs since 2021 and projects this trend to continue in the coming years. Our significant membership growth during the last two years has shifted the demographic profile and lowered our risk scores in the risk adjustment settlement calculation. Having the lowest premium level relative to the merged market average compounds the impact. Also, the federal "CSR Adjustment Factor" to account for benefit richness (or induced demand) does not adequately account for the value of ConnectorCare plans, which offer more coverage than Platinum plans.

- Silver Loading: The majority of WellSense members are enrolled in ConnectorCare plans and are expected to receive Federal and State Cost-Sharing Reductions (CSRs) in accordance with ACA regulations. The "Silver Loading" represents the additional premium applied to the Silver A II plan to account for the assumption that no federal CSR funding will be provided. The anticipated discontinuation of the expansion ConnectorCare pilot program will shift the member mix in the Silver A II plan, which will increase our Silver Loading requirement for 2026 rates.

- Unanticipated cost pressures for CY 2024 and CY 2025: As we developed rates for 2024 and 2025, WellSense was still experiencing very favorable base claims and a moderate claims trend. For 2024 and 2025, WellSense delivered annual rate increases of -3.3% and 5.7%, respectively, allowing our plans to serve as the most affordable choices in the Massachusetts' merged market. However, with significant growth from MassHealth redeterminations and the 2024-25 ConnectorCare expansion pilot, our membership demographic and utilization patterns have shifted substantially. The base experience, emerging trends, and projected risk adjustment payments all indicate an atypical increase in our 2026 base rate is necessary to ensure that WellSense remains financially viable while still providing comparatively affordable options to consumers, especially those receiving federal and state subsidies. From a three-year perspective, WellSense's average annual increase from 2024 to 2026 remains below 6%, which is lower than the market average. Additionally, most of WellSense's members are in the ConnectorCare plans, where they will see very limited premium increases due to the cap imposed by the Health Connector's affordability schedule.

See the accompanying file called "Exhibit for Public Release" for additional details.

SUMMARY OF COST-SHARING AND BENEFITS

See the accompanying file called “Exhibit for Public Release.”

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

The process for setting provider contract rates begins with the base rate, which is modeled on MassHealth reimbursement rates and methodology. The payment methodology may vary by provider type and includes: All Patient Refined Diagnosis Related Group (APR-DRG) methodology, per diem, per case, per visit, per unit, fee schedule, and a percent of charges.

In addition to using MassHealth base rates as a benchmark, WellSense considers market forces and provider negotiations when determining reimbursement rates. We may offer higher rates to ensure network adequacy in certain geographic locations and to maintain our competitiveness in the marketplace.

We have also implemented shared savings incentive programs for some of our providers to encourage high quality, cost-effective care. These providers are eligible to receive financial incentives based on their ability to meet quality and cost targets.

WellSense conducts an annual review of our payment terms, and we do not anticipate any significant modifications to our provider reimbursement methodology and rates in the immediate future.

SUMMARY OF ADMINISTRATIVE EXPENSES

See the accompanying file called “Exhibit for Public Release.”

MEDICAL LOSS RATIOS

See the accompanying file called “Exhibit for Public Release.”

CONTRIBUTION TO SURPLUS

WellSense has built in a 1.9% contribution to surplus, as allowed by Massachusetts law.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

The information used in the rate filing may differ from the information contained in the filed financial statements due to the following reasons:

- Different claims paid-through dates: The CY 2024 claims experience used to develop the 2026 rates reflects claims paid through February 28, 2025. In contrast, the claims in the CY 2024 financial statements are those paid as of December 31, 2024. Additionally, the base claims in the rate filing exclude anti-obesity GLP-1 claims.

- Use of the incurred period vs. inclusion of retroactive adjustments: The majority of the financial information and membership data utilized in the rate filing are incurred-based, meaning the statistics are recorded when incurred in CY 2024. The CY 2024 financial statements may include retroactive payments, receivables, or adjustments for prior periods.

- Different allocation methods: The financial statement may employ a different allocation method or base for certain expenses or other financial statistics.

COST CONTAINMENT PROGRAMS

WellSense has cost containment programs that focus on clinical programs and care and utilization management.

Clinical Programs

The areas of focus for each CM program include but are not limited to keeping members healthy, managing members' emerging risk, addressing member safety issues and concerns across various settings, and managing multiple chronic illnesses.

Additionally, WellSense has several medical management programs aimed at supporting individual member needs, such as health care education, disease management, population health management, transition of care, complex care management, and behavioral health services.

HealthCare Education

HealthCare education is a core activity targeting the general population as well as members identified with specific emerging risk or chronic illnesses. The educational materials consist of tools, and resources to promote wellness and prevention, and to provide new and easy ways for members to manage illness and stay healthy. I n addition, we offer multiple self-management programs such as chronic disease, chronic pain, diabetes and building better caregivers. Other topics include prevention activities related to childhood and adult immunizations, general nutritional tips, home and safety reminders, as well as condition specific education via traditional mailings, text messaging and online material.

Disease Management

Addresses chronic disease states, such as asthma and diabetes, and monitors the member's current status and provide education and outreach aimed at helping members understand their disease and the self-management they can do to optimize their health and safety.

Population Health Management

Addresses members with medical, behavioral, and social needs and interventions for specified diagnoses. This involves assessing the member's condition and/or emerging risk, coordinating care and services, and determining available benefits and resources, such as family support and community resources. An Individual Care Plan (ICP) is developed and implemented for the

members, emphasizing psychosocial support, self-management goals, care coordination, ongoing monitoring, personal and home safety, and appropriate follow-up.

Transition of Care

This program targets members discharged from any setting throughout the healthcare continuum (emergency department, acute inpatient, and post-acute facilities). The Care Transition Program aims to meet the goal of mitigating unnecessary emergency department encounters and reducing inpatient readmission within 30 days of discharge. Through the member assessment and ICP, the program also aims to provide available benefit services and resources to keep the member in the least restrictive setting.

Complex Care Management (CCM)

The CCM program targets members with multiple complex illnesses, including those stratified as the highest risk and may include members with special health care needs. The program involves a multidisciplinary approach to assessing the member's clinical status and associated social determinants of health. The program emphasizes consensual face-to-face member meetings, coordination of care through the health care continuum, and determination of available benefits and resources including family support and community resources / partners.

Behavioral Health Care Management (BH CM)

WellSense offers support to our members with certain behavioral health conditions. Our behavioral health care coordinators are trained to help members with access to behavioral health services and can help with finding a behavioral health counselor and community resources near the member or explaining available treatment options.

WellSense also offers a Behavioral Health Enhanced Care Coordination (BH ECM) program to provide additional support. This is a care management program provided for WellSense members who are experiencing complex behavioral health or psychosocial conditions, sometimes in addition to medical concerns. BH ECM is a voluntary, flexible, short-term program to meet the individual needs and promote optimal behavioral health.

Utilization Management

WellSense performs utilization management for medical services such as inpatient stays and outpatient services. Additionally, WellSense performs pharmacy management, including prior authorization, quantity limits, step therapy, and formulary management.