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

OVERVIEW OF THE FILING

Name of Company: ……..	Fallon Community Health Plan Inc.
Actuary Responsible for Filing: ……	Michelle Anderson FSA, MAAA
Period of Rate Filing: ……..	Issued/renewed in CY2026
Number of Plans Filed: ……..	7 unique plan designs
Number of Renewing Individuals and Dependents: ……	22,906
Number of Renewing Small Groups: ……..	103
Number of Renewing Small Group Members: ……	292
Average Adjusted Rate Change over Prior Period: ……..	9.9%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

The 9.9% rate change is driven by the following key components:

- 9.8% rate increase due to the risk adjustment transfer
- -3.0% reduction due to base period cost and trend restatement
- 3.5% attributed to claim cost increases due to enhanced subsidy expiration and Connector Care expiration
- -0.4% reduction due to administrative costs

See accompanying information included within “Exhibit for Public Release” for more detail.

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying information included within “Exhibit for Public Release” for more detail.

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

Fallon Health’s general rate setting methodology sets base rates each year at a percentage of the payment rates used by CMS for the Medicare program in "Metropolitan Boston" or the "Rest of Massachusetts" distinctions. In most cases, Fallon Health establishes its base rates at 100% of Medicare. Reimbursement methods include Diagnostic Related Groupers (DRGs), Per Diems, Per Case Rates, set Fee Schedules, Hourly Rates and Percent of Charge for most services. For services not covered by Medicare, Fallon Health generally uses its commercial percent of charge base reimbursement.

If a provider does not accept Fallon Health's default base rate fee schedule, Fallon Health negotiates with the provider to arrive at mutually agreeable payment rates. Fallon Health considers the following factors in any such negotiation: geography, types of services/specialties provided, provider reputation,

provider brand recognition/consumer demand, geographic access to services need, cultural needs of a specific community, size/bargaining power of provider and possibly other similar factors.

In addition, Fallon Health may include incentives tied to provider performance, such as quality incentives, to mutually focus providers on HEDIS requirements and member experience. Other payments not tied to service or performance can be used as a negotiation approach to support management or provider infrastructure.

SUMMARY OF ADMINISTRATIVE EXPENSES

See accompanying information included within "Exhibit for Public Release" for more detail.

MEDICAL LOSS RATIOS

See accompanying information included within "Exhibit for Public Release" for more detail.

CONTRIBUTION to SURPLUS

Fallon Health is targeting a contribution to surplus of 1.8% of premium for all plans in the 2026 rate development. By MA law and NAIC standards, Fallon Health and all other carriers must maintain certain risk-based capital levels which have to be funded by ongoing operations. This target helps ensure Fallon Health has adequate reserves, which protect against downturns in the underwriting cycle and allows us to continue serving the merged market.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

The information used in Fallon Health's rate filing reconciles to financial statements. Key reconciliation factors include:

1) Our rate filing information has prior period items removed to get an accurate picture of our base period experience.
2) There are timing differences between when the rate filing and financial statements are completed. If new information comes to light after financial statements are filed, such as updated Risk Adjustment transfer expectations, this will be reflected in the rate filing.
3) Fallon Health's financial statements include Commercial Merged Market experience for more than just Community Care products, while the rate filing information is limited to Community Care only. Fallon Health exited these non-Community Care products starting in 2022, but there was as wind down period that extended throughout 2022, with the potential for runout into 2023. Financial information for these products may be included in financial statements but is not relevant to our 2026 rate filing.

COST CONTAINMENT PROGRAMS

In order to maintain premiums, co-payments, cost shares, and deductibles at affordable levels, Fallon Health continually works to manage the cost of care. This includes, but is not limited to, eliminating or minimizing duplicative, unnecessary, or inappropriate care. It also includes supporting initiatives and activities that improve the quality of care.

The principle under which our cost of care team designs, builds and implements programs is to deliver the right care to the right patient in the right setting without duplication, errors, or gaps in care, resulting in the most effective care and the best outcomes for our members. Fallon Health cost containment activities address the cost of care across six major areas: unit cost, utilization, fraud and abuse, payment policy, benefit design and specialty drugs. Achieved or anticipated cost of care savings are applied to base period expenses or to trend adjustment factors in the development of premium rates.

Fallon Health continues to enhance management of pharmacy benefit drugs in partnership with our pharmacy benefit manager (PBM) OptumRx who provides significant local experience and extensive knowledge in supporting NCQA HEDIS measures and government programs, as well as digital technology support.

Fallon Health continues to enhance management of medical benefit medications through prior authorization and post service claims edits. The prior authorization process is streamlined to allow providers to submit prior authorization requests through a web-based portal in addition to facsimile or telephonically. The criteria will include site-of-service requirements to direct members to the lowest cost setting in which to receive treatment. Fallon Health continues to expand post-service pre-payment claims edits for medical benefit pharmaceuticals to ensure reimbursements are consistent with industry standards and current Fallon Health Medical and Payment policies. Fallon Health additionally works with providers to transition members from costly outpatient visits to lower cost, member-friendly home infusion for select drug therapies. In addition, as biosimilar therapies become more widely adopted, Fallon Health has implemented preferred strategies (where medically appropriate) for these lower cost options. Fallon Health also continues to expand the rebate program to include medical benefit drugs.

Fallon Health continues to perform retrospective pharmacy claim review for retail and mail service claims in the following areas of focus: appropriate therapy management, condition management, dose optimization management, GI therapy management, therapeutic duplication management, age-appropriate therapy management, and duration of therapy management. Communications are sent to the prescriber within 72 hours of the claim utilizing member-specific, evidence-based recommendations.