Health New England

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

OVERVIEW OF THE FILING

Name of Company: ..... Health New England, Inc
Actuary Responsible for Filing ..... Jesse Jenkins, ASA, MAAA
Coverage Period for Rates Filed: ..... Issued/renewed in CY2026
Number of Plans Filed: 34
Number of Renewing Individuals and Dependents: 7,947
Number of Renewing Small Groups: 2,243
Number of Renewing Small Group Members: 16,937
Overall Average Proposed Rate Change over Prior Period: 10.4%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

- Health insurance premiums reflect the cost and usage of medical care and services. Health New England (HNE) has been impacted by increases in these areas due to higher costs and utilization of medical services and prescription drugs. As a result, our medical and pharmacy trends continue to rise.

- The largest driver of HNE's 2025 requested rate increase is a rise in the costs of medical services and drugs. Pharmacy costs are expected to increase by 10.5% in 2026. This increase is driven by increased use of specialty drugs and the growth of new therapies. Members are also expected to use 3% more prescription drugs in 2026.

- Physicians and hospitals are facing economic pressures caused by supply chain shortages, overall inflation and continued workforce challenges. As a result, providers are seeking higher reimbursement for their services. HNE continues to be diligent but is routinely required to increase service reimbursement rates at levels that exceed the 3.6% cost control benchmark, established by the MA Health Policy Commission, to maintain its current provider network.

See accompanying file called "Exhibit for Public Release" for additional detail.

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying file called "Exhibit for Public Release."

Health New England

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

HNE uses several contracting approaches with providers to help control costs. The different payment methodologies are used to help members get the highest quality care at the lowest cost. These methods include fee-for-service, valuebased arrangements and quality incentives.

Providers paid on a fee-for-service methodology receive a fixed amount or a percent of billed charges based on the service provided to the member. The amounts paid reflect the level of care provided and are set to appropriately reimburse the provider for the care provided to the member.

Value-based arrangements reimburse providers that offer quality care at the lowest possible cost. Physicians and hospital systems are rewarded for providing the appropriate level of care to members at a cost that is consistent with cost targets. Providers are further reimbursed if quality metrics are met.

Providers are encouraged to expand preventive care options, address chronic conditions and improve the overall health and experience of our members. As the providers hit certain metrics bonus payments are provided. This system helps members get the highest quality care.

HNE reviews publicly available data to make sure reimbursement rates to hospital systems remain competitive and give members services at a cost that is in line with the competition. Contracts renew on a 2-4 year cycle and are adjusted to try to control medical inflation.

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

Contribution to surplus (the proportion of premium to be set aside to fund future unexpected costs) is set at 2.5% of premium. This level will allow Health New England to maintain an appropriate level of capital to respond to unforeseen health care events. With this value, the target Medical Loss Ratio (MLR) for this filing is 88.9%, which is above the minimum MLR standard of 88.0%.

Health New England

DIFFERENCES FROM FILED FINANCIAL STATEMENT

Any differences from filed financial statement are driven by additional claim information and other timing updates, or by minor classification differences.

COST CONTAINMENT PROGRAMS

Health New England's Care Management Department provides a team-based, member-centered approach to effectively and efficiently manage populations, their medical conditions and social determinants of health. Care Management (CM) also encompasses those care coordination activities needed to help manage complex chronic illnesses. The program is comprised of licensed nurses and social workers acting as clinical advocates. They provide member education, care management, and coordination of care services across the continuum of care.

Care Management programs help control costs for members while maintaining the highest level of quality of care. The programs include:

Diabetes Program: This program stresses the importance of self-management. The program provides members with education, information, and assistance to help them improve their self-management skills which include: creating action plans, setting and attaining goals, problem solving, fatigue management, making daily tasks easier, dealing with negative emotions, improving nutrition, and becoming more physically active and much more. All HNE members age 18 and over with diabetes are eligible to participate in this program at no additional cost. Pediatric and Adult Asthma Program: This program assists members to achieve and maintain effective asthma control. Participants learn how to avoid and control triggers, use medication correctly, and improve self- management skills to prevent exacerbation of symptoms. The Program is targeted at members of all ages and interventions are age-appropriate, at no additional cost. Coronary Artery Disease (CAD): The program focuses on members with a current diagnosis of CAD and on members with multiple CAD risk factors such as high blood cholesterol, congestive heart failure, and diabetes. The overall goal of the CAD program is to support the physician's plan of care by assisting members to improve self-management skills, and to lower blood cholesterol, prevent progression of the disease, promote recovery from acute coronary events, prevent repeat acute coronary events, and maintain an overall quality of life. All HNE members aged 18 and over with diabetes are eligible to participate in this program at no additional cost.
Chronic Obstructive Pulmonary Disease: Symptoms of Chronic Obstructive Pulmonary Disease (COPD) include chronic cough, difficulty breathing, wheezing, tightness in your chest, frequent respiratory infections and lack of energy. If you have been diagnosed with COPD, our COPD program is designed to help support your provider's plan of care,

provide educational materials and coaching as well as guidance on lifestyle changes, managing exacerbations and use of medications.

Congestive Heart Failure: Those with Congestive Heart Failure (CHF) struggle with shortness of breath, fatigue, swelling and sudden weight gain from fluid retention, lack of appetite and nausea, and persistent cough or wheezing. Our CHF program supports your provider's plan of care and your self-management by guiding you with your medications, daily weights, fluid and salt restriction and healthy lifestyle habits.

High Risk Maternity: Pregnancy is a special time for expectant mothers and most can look forward to delivery of a healthy baby at full term – 37 weeks or more gestation. However, sometimes complications can occur during pregnancy that are unexpected.. Health New England has partnered with Babyscipts, a digital maternity care tool that connects pregnant commercial Fully-funded and Medicaid members with "trimester" specific education platform. Members can access Babyscripts via an "app" on their phone or tablet or a website. If needed, the members obstetrician can order home blood pressure monitoring which may avoid unnecessary hospitalizations. i, members. The Babyscripts platform provided not only gestational age specific information to the member, but also supports care coordination, collects and shares key assessments with their OB providers or HNE CMs, such as SDoH screenings and Postpartum Depression Screenings.

NICU Management: Having a baby prematurely or born with complex medical needs is stressful for the parents. HNE as engaged ProgenyHealth to assist our Commercial Fully-funded members navigate their newborn's NICU stay and beyond, proving care management support up to the baby's 1st birthday. The ProgenyHealth care management team works with the NICU staff to ensure that the appropriate NICU level of care is authorized, collaborates with HNE to obtain all necessary post discharge services and care are in place, and will provide ongoing support to the family as they care for a baby with a variety of care needs.

Hypertension: One in three American adults has hypertension or high blood pressure, a condition that can result in heart disease or stroke. If you have been diagnosed with hypertension, our Hypertension program can provide you with educational materials and work with you and your provider to address ways to reduce and control your blood pressure such as eating a healthier diet, exercising regularly and if you smoke, help you to quit.

Depression Program: Those struggling with depression know that it has serious effects on their overall health, daily functioning and the lives of their families and loved ones. Our Depression Care Management Program provides support for our members that include: arranging, coordinating and advocating for services such as counseling, crisis services, community resources and support groups. Behavioral Health: Mental health problems have a real effect on daily living activities and an impact on overall quality of life. Our Behavioral Health Care Management Program works with our members to help find them the services they need such as educational materials and referrals to counseling,

medication management, day programs, state agencies, and community resources. Substance Use Disorder: Excessive alcohol and drug use are often associated with high utilization and costs. Our Substance Use Care Management Program assists members with locating inpatient substance abuse programs, making referrals to outpatient services, and connecting member with crisis services, support groups, medication assisted treatment, and family supportive services. Social Work Case Management: The conditions in which people are born, grow, live, work, and age affect their overall health and well-being. Our Social Care Management program seeks to help members meet not only their health needs, but their environmental and basic living needs. We help our members find resources like safe, affordable housing, healthy and affordable food, affordable medication and community resources and support groups.
Dual Diagnosis Program: (SPMI/SUD and chronic medical condition (diabetes, CHF, or COPD): The goal of the Dual Diagnosis (Serious Persistent Mental Illness/Substance Use Disorder) and chronic medical condition Care Management (CM) program is to improve members behavioral and medical health outcomes, decrease associated costs and reduce inconsistencies in service delivery. Members work with a Behavioral Health Care Manager to develop a plan of care based on a disease-specific assessment of the member's behavioral health and medical condition in accordance with clinical guidelines. The plan of care prioritizes the members' needs, identifies goals and interventions to address those needs as well as barriers to care. Goals include, but are not limited to, supporting the provider's plan of care and assisting members with achieving and maintaining control by ensuring appropriate treatment, adherence to treatment, and improving self-management skills. Pathway Home (Transition of Care)**: Medicare Advantage members identified with highest risk of hospital readmission will be met by a Care Manager in the hospital to enroll in the TOC program. The Care Manager will work with member and family to coordinate post-discharge services, including follow up appointments with PCP.