

OVERVIEW OF THE FILING

Name of Company: Harvard Pilgrim Health Care, Inc.
Actuaries Responsible for Filing: Jenn Smagula, FSA, MAAA
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Coverage Period for Rates Filed:	CY 2027
Number of Plans Filed:	44
Number of Renewing Individuals and Dependents:	12,925
Number of Renewing Small Groups:	4,542
Number of Renewing Small Group Members:	66,393
Overall Average Proposed Rate Change over Prior Period:	6.7%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

See accompanying file called “Exhibit for Public Release” for additional detail.

- **Medical Trend:** A key driver of health insurance premium increases year-over-year is medical trend, which is comprised of inpatient, outpatient, and physician services. Medical trend includes both increases in the cost of the services provided by hospitals and physician groups and increases in the utilization and severity of these services by our members.
 - For 2026 and 2027, Harvard Pilgrim expects there to be continued upward pressure on medical cost increases, driven by the higher inflationary environment and labor shortages that have led to providers requesting higher rates of reimbursement. While Harvard Pilgrim expects to successfully partner with hospitals and physicians across the state to moderate these cost increases, and continue to make quality care accessible for all, the increases are expected to be above historical levels.
 - Harvard Pilgrim also continues to experience elevated medical utilization & severity trends. Utilization has increased across multiple categories of services and is not driven by any single event or service type.
- **Pharmacy Trend:** Pharmacy spend continues to put significant upward pressure on overall claim trend, particularly for brand drugs such as Immunomodulators, oncology drugs and other high-cost specialty drugs, and this is expected to continue in 2027. Note that as of January 2026, Harvard Pilgrim no longer covers GLP1 for weight loss indications; the reduction in expected future claim costs for this change in coverage is reflected in the filed rates.
- **Risk Adjustment:** Both actual and projected changes in the risk of Harvard Pilgrim members, relative to the market, results in a higher expected receivable for Harvard

Pilgrim. This is helping moderate the increase, partially offsetting the medical and pharmacy trends.

- Other drivers of the rate change include a provision for the anticipated impact of the revised PACT Act and recently finalized prior authorization regulations, updated administrative cost assumptions, and the impact from the updated base period experience.

Table 3 of the Exhibit for Public Release shows the annualized trends used for this filing. Note that for pharmacy trends, mix is part of unit cost, not utilization.

Table 3: Annualized Trend Assumption CY 2027

Allowed Trends	Prescription		Total
	Medical	Drug	
Utilization & Mix	7.2%	2.6%	6.0%
Cost (Price)	3.2%	9.1%	4.8%
Total	10.7%	11.9%	11.1%

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying file called “Plan and Benefit Template.”

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

Harvard Pilgrim leverages industry standard methodologies to establish rates for our providers. Plan participating professional providers are predominantly reimbursed on a fee for service basis using fee schedules based upon the Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS). For inpatient services, over 70% of the hospitals in our network are reimbursed using Diagnosis Related Groups (DRG) methodology, where a relative weight is assigned to each inpatient service; either All Payor Refined (APR) DRG or Medicare MS DRG is used for our hospitals reimbursed on a DRG basis. Our outpatient services are reimbursed using a proprietary fee schedule that was created by leveraging Medicare outpatient methodologies and rules.

The physicians who care for our members may be compensated in several different ways. Some large physician groups, with strong and robust practices with a high level of sophistication and infrastructure, can manage under a high-risk capitation model. Smaller independent provider groups are more aptly suited to the quality incentive programs under a performance-based model.

We maintain a portfolio of financial models (Pay for performance, Shared Savings, Shared Risk and Full Risk) that support the goal of efficient and coordinated delivery of high-

quality health care with improved outcomes.

By offering different financial models, we strive to align payment arrangements with providers to achieve the appropriate balance of the right level of compensation and desired standards of performance. The compensation amount varies by model and depends on achievement of financial, clinical, or service goals.

SUMMARY OF ADMINISTRATIVE EXPENSES

See accompanying table, “Actual Historical Administrative Expenses” in the Exhibit for Public release, replicated here:

Table 5: Actual Historical Administrative Expenses

	CY 2024 Total Dollars	CY 2024 PMPM	CY 2025 Total Dollars	CY 2025 PMPM
Taxes and Fees	\$6,615,918	\$5.24	\$7,539,923	\$6.08
Other Administrative Expenses	\$100,036,737	\$79.29	\$92,600,673	\$74.72
Total	\$106,652,656	\$84.54	\$100,140,596	\$80.80

MEDICAL LOSS RATIOS

See accompanying table, “Medical Loss Ratio”, in the Exhibit for Public Release, replicated here:

Table 6: Medical Loss Ratio

	CY 2023	CY 2024	CY 2025	Proposed 2027 Rates
Medical Loss Ratio	86.0%	88.8%	90.5%	91.2%

Rates are set to ensure meeting the 88% minimum loss ratio requirement. Massachusetts requires that at least 88% of premium must be used for medical expenses (otherwise, a rebate is paid to subscribers). The rate change is calculated to comply with this requirement.

CONTRIBUTION TO SURPLUS

Harvard Pilgrim rates include 1.90% for contribution to surplus. This margin helps maintain financial stability and ensures that Harvard Pilgrim can continue to pay claims and invest in its members, despite the significant uncertainty that is present in the market and healthcare industry. Note that this contribution to surplus is within the allowable range dictated by the DOI.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

Information within the rate filing is different from filed financial statements largely due to timing. Financial statements include restatements for prior years. In addition, the amount of claims run-out, or time between the incurred and paid dates may vary between the rate filing and financial statements.

Most financial statements also include the experience for the entire Harvard Pilgrim book of business, whereas the information in this filing represents Merged Market experience only.

COST CONTAINMENT PROGRAMS

Harvard Pilgrim has a robust portfolio of cost management programs aimed at keeping care affordable. Every year the portfolio is evaluated, and new initiatives are implemented.

Program Name	Program Description
Utilization Management	Harvard Pilgrim Health Care covers medically necessary, appropriately authorized services in accordance with the member’s benefits. To ensure the quality of care, we monitor authorization, medical necessity and appropriateness and efficiency of services rendered. Certain services require a referral, prior authorization and/or inpatient notification to confirm that the member’s PCP, Harvard Pilgrim, or an approved vendor on behalf of Harvard Pilgrim has approved the member’s specialty care and/or inpatient services. Providers should submit referrals, prior authorization and/or inpatient notifications in accordance with the requirements and time frames outlined in the Provider Manuals.
Care Management	This program provides services to enrollees who have complex medical and/or behavioral health conditions and may also have social determinants of health needs (such as food and/or housing instability). As the enrollees have complex care needs, the program services involve close collaboration between medical care managers, behavioral health care managers and community health workers. A unique feature of this program is its proactive approach - it screens enrollees who are at-risk for complex care issues and who are considered to be the most vulnerable. Referral into the program can be from various sources including enrollee, provider, health assessment, or claims reporting. The program team evaluates an enrollee's care needs holistically and works with the enrollee to develop the most appropriate care plan.
Transitions of Care	Transitions of Care (TOC) is an episodic service that focuses on providing care to our most vulnerable patients who are transitioning from hospital (acute, observation, ECF, ED) to home, and who, based on clinical complexity, are at a high risk for readmission to the hospital. The service aims to reduce readmissions and promote safe care transitions by using evidence-based models to focus on key mechanisms.
Payment Integrity	Payment integrity is the process through which health plans and payers ensure healthcare claims are paid accurately and timely, both in pre-pay and/or post-pay processes. Typically, this is done through embedded internal edit, audit, and reimbursement functions as well as partnerships with external vendors that bring additional expertise and resources. Functions include a robust review of claims to ensure claims are paid in accordance with contractual obligations, plan policies and procedures, member benefits and that industry standard rules are applied to prevent, detect, and remedy waste and abuse.