

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

OVERVIEW OF THE FILING

Name of company: Mass General Brigham Health Plan, Inc.
Actuary responsible for filing: Poly Barman
Coverage period for rates filed: Issued or renewed in calendar year 2027

Plan and Membership Counts

Number of plans filed: 68
Number of renewing individuals and dependents: 36,802
Number of renewing small groups: 8,106
Number of renewing small group members: 42,076

Overall Average Proposed Rate Change over Prior Period: 13.5 percent

In alignment with guidance from the Division of Insurance, this filing is based on the scenario that assumes the continuation of the ConnectorCare expansion pilot (coverage for members between 300 and 400 percent FPL). The pilot sunsets at the end of 2026 under current state law without further legislative action.

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

Mass General Brigham Health Plan was founded by community-based organizations nearly 40 years ago and continues to deliver exceptional healthcare experiences in our communities, offering nationwide access to comprehensive coverage with a reputation for excellence. The combination of competitive premiums and a focus on creating consumer-friendly products has made Mass General Brigham Health Plan a trusted choice for employers and individuals.

Our 2027 rate filing reflects a continued commitment to expanding access to convenient, affordable, and flexible care. Key investments include comprehensive mental health services, enhanced women's health programs, and innovative virtual care options designed to improve the member experience and health outcomes. At the same time, this filing reflects significant external pressures, including evolving federal and state policy changes, uncertainty around the expiration of state premium subsidies, and persistent increases in healthcare costs across the health care system.

Several key factors are driving the proposed rate increase:



- **Policy and Market Changes Impacting Affordability and Risk Pool**

The implementation of the federal law H.R. 1 also known as the One Big Beautiful Bill Act is driving significant shifts in how individuals and families qualify for coverage and what they pay for their health plans. Further, the expiration of enhanced premium tax credits has affected affordability, reducing the financial support that previously made health insurance more accessible for our members. These federal policy changes negatively affect the risk pool, through the loss of lower-risk members and limit access to more affordable plan options, particularly for our Health Connector members.

We are seeing a growth of self-insured “level funded” small group options, from 2 percent in 2021 to over 11 percent in 2025 (based on the Center for Health Information and Analysis (CHIA) Enrollment Trends Databook as of September 2025). These products are medically underwritten which pulls small groups with favorable risk out of the merged market risk pool, leading to a deterioration of the fully insured merged market risk pool and worsening affordability for individuals and small businesses who remain in the merged market.

- **Rising Cost and Utilization of Healthcare Services**

Industry-wide increases in the cost and utilization of healthcare services continue to reflect both regional and national trends. Trends are being driven by rising incidence of chronic conditions, as well as new medical technologies and treatments, which are improving outcomes, but often come at high costs set by manufacturers. This filing incorporates efforts to improve the effectiveness and efficiency of utilization management and care management processes through investment in greater integration between plan and provider from both a technology and a payment perspective.

- **Accelerated Pharmacy Trends**

Pharmacy costs remain a significant driver of trend, particularly due to increased utilization of specialty medications and the introduction of new, high-cost therapies. For some conditions, such as diabetes, per-patient spending, rather than price alone has increased, due to more intensive treatment and management with higher cost treatments. Despite discontinuing coverage for GLP-1s for weight loss, we continue to see rising utilization for diabetic GLP-1s as these treatments increasingly are being used to treat diabetes and expanded for other conditions. MGBHP has accelerated the use of formulary and pipeline management strategies aimed at reducing pharmacy spend by evaluating areas such as alternatives to clinical duplicates, including movement to biologic equivalents for some specialty medications and adjusting preference away from high-cost brands and generics.

- **Investments in Access and Member-Centered Care**

The rate filing incorporates strategic investments to improve access to high-quality, affordable care. These include a robust women’s health portfolio, expansive behavioral

health and mental health solutions, virtual primary care services, and digital tools designed to enhance member engagement and care coordination.

Overall, the proposed rate change reflects a balanced approach to managing these cost pressures while continuing to provide comprehensive, high-quality coverage. Mass General Brigham Health Plan remains focused on mitigating cost increases through targeted pharmacy and care management initiatives, operational efficiencies, and disciplined administrative cost management, while investing in programs and innovations that improve affordability, access, and member outcomes.

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

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying file called “Plan and Benefit Template.”

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

Mass General Brigham Health Plan approaches provider contracting with the following goals in mind:

- Ensure that total cost of care increases are as low as possible while ensuring access to high-quality care through implementation of actuarially sound, value-based contractual elements and alternate payment methodologies;
- Ensure actual rate levels and unit cost reimbursement levels are competitive with Mass General Brigham Health Plan peers and create stability over time;
- Ensure provider participation that meets both network adequacy requirements and market expectations;
- Ensure administrative simplicity through the use of standardized reimbursement methodologies and fee schedules where possible;
- Improve affordability and equitable access to providers;
- Utilize industry standard payment methodologies such as relative value professional fee schedules and diagnostic-related groups for inpatient hospital;
- Include quality incentives in all alternative payment contracts.

There are several reasons why we have variation in provider reimbursement. Provider reimbursement can vary by network, such as our Select offering where providers have offered a discount for the subsidized membership to support plan affordability and minimize provider

disruption. Additionally, providers' rates can vary based on the level of specialization of services provided, historical rate levels, and regional access.

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 current rate filing includes 1.9 percent contribution to surplus. Merged Market rates are filed with a target medical loss ratio of 91.9 percent, which is above the minimum medical loss ratio standard of 88.0 percent.

Contribution to surplus provides some protection against unforeseen trend and other insurance risk given the long projection period included in the rates and supports risk-based capital surplus requirements.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

The primary differences between historical premiums, claims, and expenses outlined in this filing and those reported in financial statements are as follows:

- Incurred vs. Paid differences – Financial statements are reported on a point-in-time paid basis and include any prior period estimated changes, whereas the rate filing information is on a point-in-time incurred basis.
- Some items are classified differently in financial statements compared to rate filing.

COST CONTAINMENT PROGRAMS

As part of an integrated healthcare system, we are creating and delivering exceptional experiences that combine world-class care and comprehensive coverage. Mass General Brigham Health Plan is expanding access to high-quality and affordable healthcare, centered on the health and wellness needs of our members. Initiatives include:

- Providing extensive clinical and care management programs for at-risk members. Focused on prevention, chronic disease management and social determinants of

health, our care management programs comprise multi-disciplinary teams of experts that include nurses, social care managers, behavioral health managers, and medical directors. We are extending this approach into the community through programs that connect members experiencing a range of medical, psychological, and social health challenges with community-based resources. As part of an integrated healthcare system, we also address these challenges through Mass General Brigham's Home Hospital program, which delivers high-quality care and recovery support in the convenience of patients' homes. The programs are estimated to return two dollars for every one dollar invested and an ongoing impact on future trend of 0.3percent on medical trend annually.

- We continue to respond to the ongoing mental healthcare crisis by supporting family health and providing timely access to mental healthcare services. Our comprehensive solution offers access to mental health professionals from across the country, and we recently added a robust teen mental health program for teens experiencing anxiety and depression, complemented by parent and caregiver coaching.
- Driving affordability through product design that encourages the use of more convenient and affordable sites of care in the community when appropriate through innovative networks and plan designs such as Care Complement, Allies Choice, and Choice Easy Tier Choice Products. We strategically worked to align our cost share and benefits to promote lower cost sites of service for care.
- Mitigating the high cost of pharmaceuticals to improve affordability for our members through pharmacy benefit manager (PBM) contracting and formulary management, encouraging biological equivalents when clinically appropriate, and directing members to lower-cost provider sites. Savings associated with anticipated formulary changes contributed to lowering the overall rate increase.
- We implemented an integrated care management model on a digital platform to enhance provider collaboration and coordinate member care. Real-time data enables earlier interventions and connects members with chronic and complex care management after discharge, with the aim of reducing emergency visits and readmissions. By guiding members to appropriate, lower-cost care settings, we can improve health outcomes and the overall member experience.