# 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/renewed in CY 2024

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|---|---|
| Number of Plans Filed: | 63 |
| Number of Renewing Individuals and Dependents: | 17,263 |
| Number of Renewing Small Groups: | 749 |
| Number of Renewing Small Group Members: | 5,129 |

Overall Average Proposed Rate Change over Prior Period: 7.4%

## KEY DRIVERS FOR THE PROPOSED RATE CHANGE

*[3-4 bullets or paragraphs about key drivers for proposed change]*

Mass General Brigham Health Plan's proposed rate filing for 2024 reflects anticipated, industry-wide increases in the cost and utilization of healthcare services, and investments in strategic initiatives that expand access to high-quality healthcare for our members.

The market factors that impacted our rate filing include:

- A challenging operating environment for providers due to rising labor costs, capacity challenges and inflation, which are creating upward pressure on commercial reimbursement rates.
- An uptick in the utilization of services, especially for outpatient and specialty pharmacy services.
- Additional costs associated with changes in mix of services, new-to-market therapies and higher patient acuity due to the deferment of care during the COVID-19 pandemic.
- New government requirements for products and rating.

Additionally, our rate filing incorporates continued investments in mental healthcare with the launch of an innovative new network solution that has sped access to essential mental health services.

The rate change is being offset by efforts developed to manage costs. These include pharmacy and care management services initiatives, and product designs that improves affordability by encouraging care delivery in appropriate settings.

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."

## GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

*Two-three paragraphs describing the following:*

*"An explanation of the general methodology for establishing rates of reimbursement for providers; any proposed changes in the methods of paying providers or provider contracting initiatives; the basis for paying similarly situated providers within a provider network different rates of reimbursement including, but not limited to, quality of care delivered, mix of patients, geographic location at which care is provided; and any non-fee-for-service and non-capitation payments to providers included in the rate filing, including, but not limited to, bonuses and incentives tied to provider performance and other payments not tied to service or performance." "An explanation of the general methodology for establishing rates of reimbursement for providers; any proposed changes in the methods of paying providers or provider contracting initiatives;*

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 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 of 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's 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

One paragraph describing the following:

"Contribution to surplus and the reasons that the Carrier filed at that level"

The current rate filing includes 1.9% contribution to surplus. Merged Market rates are filed with a target medical loss ratio of 90.0%, which is above the minimum medical loss ratio standard of 88.0%. 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

One-two paragraphs describing the following:

"An explanation of how or why information contained in the rate filing is different from information contained in the Carrier's filed financial statements"

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 includes 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 statement compared to rate filing.

## COST CONTAINMENT PROGRAMS

Four-five paragraphs describing the following:

"A description of cost containment programs the Carrier is employing to address health care delivery costs and a summary of the realized past savings and projected savings and projected savings from all such programs"

Mass General Brigham Health Plan is expanding access to high-quality and affordable healthcare through integrated care models. Our integration with Mass General Brigham provides a platform for collaboration and innovation in value-based care, which shifts the basis for healthcare financing and delivery from the quantity to the quality of services provided. 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 such as Your Care Circle, which connects 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 Care program, which delivers high-quality care and recovery support in the convenience of patients' homes. Programs are estimated to have a 2:1 return on investment and an ongoing impact on future trend of 0.3% on medical trend annually.

- Responding to the mental health crisis by providing a comprehensive network solution to improve access to high-quality mental health services. This approach builds on Mass General Brigham Health Plan's existing mental health programs, which include on-staff recovery coaches for members with substance use disorders, and supports our longstanding commitment to address health equity in our communities. We expect this to initially increase behavioral health costs due to expanded access, with long term savings as needs are better addressed.

- Driving affordability through product design that encourages the use of more convenient and affordable sites of care in the community when appropriate. Through our Allies Choice suite of products, our members can receive personalized care and support delivered by a high-performing tiered provider network within a community-based setting, such as Newton-Wellesley Hospital, Salem Hospital, or South Shore Hospital. Allies Choice plans premium reflect over 10% savings relative to our full network.

- Mitigating the high cost of pharmaceuticals to improve affordability for our members through pharmacy benefit manager (PBM) contracting, encouraging biological equivalents when clinically appropriate, and directing members to lower-cost sites of service. Savings associated with anticipated pharmacy contractual improvements contributed to lowering the overall rate increase by about 2%.

# ATTACHMENT A
# COST-SHARING AND BENEFITS

# ATTACHMENT B
# RATE FILING DETAILS