Tufts Health Plan
1 Wellness Way
Canton, MA 02021
tuftshealthplan.com

TUFTS Health Plan
a Point32Health company

OVERVIEW OF THE FILING

Name of the Company:	Tufts Health Public Plans, Inc.
Actuary Responsible for Filing:	Nicole Cullan, FSA, MAAA
Period of Rate Filing:	Issued/Renewed in CY 2025
Number of Plans Filed:	8
Number of Renewing Individuals and Dependents:	175,856 renewing in CY2025
Number of Renewing Small Groups:	7,629 renewing in CY2025
Number of Renewing Small Group Members:	25,434 renewing in CY2025
Average Adjusted Rate Change over Prior Period:	10.4% for CY2025 renewing members

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

- **Trend:** A key driver of health insurance premium increases year-over-year is medical trend, which is comprised of inpatient, outpatient, and physician services as well as pharmacy costs. Medical trend includes both increases in the cost of the services provided by hospitals and physician groups and increases in the utilization of these services by our members. In particular, increased pressure on unit cost trend and inflation, as well as continuing high pharmacy costs, drive year-over-year trend increases in medical expense.

- **Payer Assessment:** The restructured payer assessment of $8.76PMPM (estimated $18.4M) planned to be effective for 2025 is an increase over what we expected to pay for that time period, driving an increase to our rate change of 0.4%. The new payer assessment structure applies surcharges across insurers based on member count rather than applicable claims. As Tufts Health Public Plans Direct has lower average claims than other insurance carriers in the market on average, we are expecting this change in methodology to result in an increase to our assessment.

- **Morbidity:** In addition to trend, Tufts Health Public Plans has reviewed the impact of incoming members from MassHealth resulting from Medicaid eligibility redeterminations following the end of the Public Health Emergency. These members were only enrolled for a partial year during our base period, during which the claims experience for these new members resulted in an overall reduction to claims costs. We reduced our claims by a further 1.3% to adjust new member claims from a partial year to full year basis.

- **Risk Adjustment:** The migration of members resulting from the MassHealth Medicaid eligibility redetermination resulted in a reduction to Tufts Health Public Plans Direct overall risk score driving up our expected risk transfer payment compared to 2024

pricing. This change to our relative risk scores is driving 4.7% of our rate increase and is partially offset with lower claims trend and the morbidity adjustment described above.

- **Silver Load:** The Silver Load is an additional amount of premium included for our Silver 2000 II plan to cover additional Federal cost share subsidies covered for members who meet income eligibility requirements. Changes in member eligibility mix in the Silver 2000 II plan toward members eligible for less Federal cost sharing subsidies result in a lower Silver Premium Load requirement for 2025, resulting a rate reduction for Silver 2000 II.

- **Contribution to Surplus:** THPP includes a surplus of 1.7% in order to maintain financial stability and ensure that Tufts Health Public Plans can continue to pay claims and invest in its members, despite the significant uncertainty that is present in the market and healthcare industry.

SUMMARY OF COST-SHARING AND BENEFITS

See accompanying file called "Plan and Benefit Template."

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

Tufts Health Public Plans leverages industry standard Commercial, Medicare and Medicaid methodologies to establish rates for our providers. In general, providers are reimbursed at a lower rate for subsidized members compared to non-subsidized members.

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) and the Massachusetts Medicaid professional fee schedule, in addition to the Commercial fee schedule. For inpatient services, hospitals are generally reimbursed via acuity adjusted case payments which are based on a Diagnosis Related Groups (DRG) methodology, where a relative weight is assigned to each inpatient services; either All Payor Refined (APR) DRG or Medicare MS DRG for our hospitals reimbursed on a DRG basis. Our outpatient services are also reimbursed using a combination of fee schedules, primarily indexed to Medicare or Medicaid payment methods.

SUMMARY OF ADMINISTRATIVE EXPENSES

See accompanying file(s) called "Actual Historical Administrative Expenses" in the Exhibit for Public Release.

Table 5: Actual Historical Administrative Expenses

	CY 2022		CY 2023	
	Total Dollars	CY 2022 PMPM	Total Dollars	CY 2023 PMPM
Taxes and Fees	$19,377,187	$10.73	$23,139,878	$11.64
Other Administrative Expenses	$67,371,445	$37.31	$88,421,393	$44.46
Total	$86,748,632	$48.04	$111,561,271	$56.10

MEDICAL LOSS RATIOS

See accompanying file called "Exhibit for Public Release."

Table 6: Medical Loss Ratio

	CY 2021	CY 2022	CY 2023	Proposed 2025 Rates
Medical Loss Ratio	95.5%	91.0%	93.2%	91.3%

CONTRIBUTION TO SURPLUS

Tufts Health Public Plan rates include 1.7% for contribution to surplus. This margin helps maintain financial stability and ensures that Tufts Health 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 maximum allowed by the Department of Insurance. Rates and contribution to surplus are set to ensure meeting the 88% minimum loss ratio requirement. Massachusetts requires that at least 88% premium must be used for medical expenses (otherwise, a rebate is paid to subscribers). This rate increase is calculated to comply with this requirement.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

Information within the rate filing is different from filed financial statements largely due to timing. Financial statements may 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.

COST CONTAINMENT PROGRAMS

Point32 Health has a robust portfolio of cost management programs aimed at keeping care affordable. Every year the portfolio is evaluated and new initiatives are implemented with a value of approximately 1-2% of Total Medical Expense.

Program Name	Program Description
Utilization Management	Tufts Health Public Plans 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 the appropriateness and efficiency of services rendered. Certain services require a referral, prior authorization and/or inpatient notification to confirm that the member's PCP, Tufts Health, or an approved vendor on behalf of Tufts Health, 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.
Complex 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 (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.