Tufts Health Plan
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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 2026
Number of Plans Filed:	8
Number of Renewing Individuals and Dependents:	164,368 renewing in CY2026
Number of Renewing Small Groups:	7,057 renewing in CY2026
Number of Renewing Small Group Members:	22,758 renewing in CY2026
Average Adjusted Rate Change over Prior Period:	13.2% for CY2026 renewing members

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

- **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 of these services by our members. In particular, increased pressure on unit cost trend and inflation drives year-over-year trend increases in medical expense.

- **Pharmacy Trend:** spend for prescription drugs continues to put significant upward pressure on overall claim trend, particularly for brand drugs such as GLP-1s and Immunomodulators, and high cost specialty drugs, and this is expected to continue in 2026. Note that for 2026, Tufts Health Public Plans will no longer cover GLP-1 drugs for weight loss indications; the reduction in expected future claim costs for this change in coverage is reflected in the filed rates.

- **Payer Assessment:** The payer assessment has been restructured using a claims-based approach, rather than member count which was anticipated at the time of the 2025 rate filing. As Tufts Health Public Plans has lower average claims than other insurance carriers in the market, we are expecting this change in methodology to result in a decrease to our assessment, which translates to a reduction in the filed rates.

- **Expiration of ConnectorCare Pilot Expansion Program:** Changes in member eligibility for state subsidies in the Silver 2000 II plan shifts the member mix towards those who are eligible for more federal subsidies. These subsidies are handled via a Silver Load, which is an additional amount of premium included for our Silver 2000 II plan to cover federal cost share subsidies that are no longer funded by the federal government. Changes in the projected member mix for 2026 due to the expiration of the ConnectorCare subsidy expansion result in a higher Silver Premium Load requirement and thus a higher rate increase for 2026.

- **Network Changes:** Effective January 1, 2025 Point32Health and two provider systems (Boston Children's Hospital and UMass Memorial Healthcare) amicably agreed to terminate our contract for the THPP Direct product. The values in the filing include the impact of those terminations.

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 service; 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 2023 Total Dollars	CY 2023 PMPM	CY 2024 Total Dollars	CY 2024 PMPM
Taxes and Fees	$23,139,878	$11.64	$30,427,805	$12.36
Other Administrative Expenses	$88,902,638	$44.70	$107,615,215	$43.72
Total	$112,042,516	$56.34	$138,043,020	$56.08

MEDICAL LOSS RATIOS

See accompanying file called "Exhibit for Public Release."

Table 6: Medical Loss Ratio

	CY 2022	CY 2023	CY 2024	2026 Rates
Medical Loss Ratio	91.2%	93.0%	96.6%	90.8%

CONTRIBUTION TO SURPLUS

Tufts Health Public Plan rates include 1.9% 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 Division 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 the methodology used to account for membership change related to network terminations described above. Experience for members who were utilizers of these provider systems in 2024 and are no longer with Tufts Health Public Plans was carved out of the base period data for the filing to more accurately capture the projected member population. Other differences are 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

Point32Health 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	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.