

OVERVIEW OF THE FILING

Name of Company: Tufts Health Public Plans, Inc.
Actuaries Responsible for Filing: Jenn Smagula, FSA, MAAA
Amanda Carlson, FSA, MAAA

Coverage Period for Rates Filed:	CY 2027
Number of Plans Filed:	8
Number of Renewing Individuals and Dependents:	140,124
Number of Renewing Small Groups:	7,951
Number of Renewing Small Group Members:	20,442
Overall Average Proposed Rate Change over Prior Period:	11.8%

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, THPP 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 THPP 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.
 - THPP 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, THPP 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 THPP members, relative to the market, results in a higher expected payable for THPP, increasing the average rates. In particular, changes in member eligibility for state and/or Federal

subsidies are expected to change the member mix and risk profile more negatively for THPP than the market.

- 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	4.2%	1.8%	3.3%
Cost (Price)	4.2%	9.6%	6.2%
Total	8.6%	11.6%	9.7%

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

Table 5: Actual Historical Administrative Expenses

Expense Type	CY 2024 Total Dollars	CY 2024 PMPM	CY 2025 Total Dollars	CY 2025 PMPM
Taxes and Fees	\$30,427,805	\$12.36	\$29,366,578	\$13.33
Other Administrative Expenses	\$107,615,215	\$43.72	\$98,424,075	\$44.67
Total	\$138,043,020	\$56.08	\$127,790,652	\$58.00

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	92.1%	96.6%	92.2%	92.1%

Rates 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). The rate change is calculated to comply with this requirement.

CONTRIBUTION TO SURPLUS

Tufts Health Public Plan rates include 1.9% for contribution to surplus. This margin helps maintain financial stability and ensures that THPP 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.

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

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, THPP, or an approved vendor on behalf of THPP, 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.