

MERGED MARKET RATE FILING SUMMARY

(211 CMR 66.08(3)(c))

OVERVIEW OF THE FILING

Name of Company: Boston Medical Center Health Plan, Inc. (BMCHP) d/b/a WellSense Health Plan (WellSense)

Actuary Responsible for Filing: Blesilda Tuan, ASA MAAA

Coverage Period for Rates Filed: Issued/renewed in CY 2027

Number of Plans Filed: 10

Number of Renewing Individuals and Dependents: 138,226

Number of Renewing Small Groups: 522

Number of Renewing Small Group Members: 1,863

Overall Average Proposed Rate Change over Prior Period: 11.9%

KEY DRIVERS FOR THE PROPOSED RATE CHANGE

The overall average annual premium rate change is 11.9%, which is driven by the factors outlined below:

- Higher medical and pharmacy Trend:
 - Medical costs continue to increase, partly due to provider contracting dynamics. Providers often seek higher reimbursement for ACA commercial plans to offset lower government-mandated rates from public programs.
 - In addition, the Connector's 2024 Seal of Approval requirement to align provider networks across metal tiers has increased WellSense's provider costs. Changes to certain subsidized ConnectorCare plans in 2026 have also shifted members into products with higher reimbursement levels, further contributing to cost increases.
 - Behavioral health, while still a smaller share of total spending, has experienced rapid growth - exceeding 20% annually over the past two years - driven by higher utilization and increased provider rates. Although recent WellSense's insourcing efforts and contract negotiations may help moderate this trend, utilization is expected to remain elevated.
 - Pharmacy costs are also expected to remain at elevated, double-digit levels. This is primarily driven by increased use of high-cost brand and specialty medications, based on projections from our pharmacy benefit manager (PBM) and Milliman.

While anti-obesity GLP-1 drugs are excluded, a certain portion of members are expected to transition to diabetes-indicated GLP-1 therapies, where clinically appropriate, resulting in continued utilization of these high-cost medications. At the same time, manufacturer rebates have declined due to factors such as biosimilar adoption, changes in federal pricing policies, and adjustments related to the 340B program.

- **Risk Adjustment:**
Updates to the 2027 CMS HHS Risk Adjustment model - based on Wakely's simulation using 2025 experience - indicate a meaningful decrease in WellSense's relative risk score. Rapid membership growth since 2024 has also lowered average risk levels due to shifts in member demographics. In addition, WellSense's relatively lower average premium compared to the merged market increases the impact of risk adjustment transfers.
- **Contribution to Surplus:**
The 2026 approved rates included a minimal contribution to surplus of 0.1%, well below the allowable 1.9%. The proposed 2027 rates reflect a return to a 1.9% contribution to surplus, which is necessary to maintain financial stability and ensure the continued availability of affordable coverage options.

See accompanying file called "Exhibit for Public Release" for additional detail.

SUMMARY OF COST-SHARING AND BENEFITS

See the accompanying Plan and Benefit Template files.

GENERAL METHODOLOGY FOR ESTABLISHING RATES OF REIMBURSEMENT

The process for setting provider contract rates begins with the base rate, which is modeled on MassHealth reimbursement rates and methodology. The payment methodology may vary by provider type and includes: All Patient Refined Diagnosis Related Group (APR-DRG) methodology, per diem, per case, per visit, per unit, fee schedule, and percent of charges.

In addition to using MassHealth base rates as a benchmark, WellSense considers market forces and provider negotiations when determining reimbursement rates. We may offer higher rates to ensure network adequacy in certain geographic locations and to maintain our competitiveness in the marketplace.

We have also implemented shared savings incentive programs for some of our providers to encourage high quality, cost-effective care. These providers are eligible to receive financial incentives based on their ability to meet quality and cost targets.

WellSense conducts an annual review of our payment terms, and we do not anticipate any significant modifications to our provider reimbursement methodology and rates in the immediate future.

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

WellSense has built in a 1.9% contribution to surplus, as allowed by Massachusetts law.

DIFFERENCES FROM FILED FINANCIAL STATEMENT

The information used in the rate filing may differ from the information contained in the filed financial statements due to the following reasons:

- Different claims paid-through dates: The CY 2025 claims experience used to develop the 2027 rates reflects claims paid through March 31, 2026. In contrast, the claims in the CY 2025 financial statements are those paid as of December 31, 2025. Additionally, the base claims in the rate filing exclude anti-obesity GLP-1 claims.
- Use of the incurred period vs. inclusion of retroactive adjustments: The majority of the financial information and membership data utilized in the rate filing are incurred-based, meaning the statistics are recorded when incurred in CY 2025. The CY 2025 financial statements may include retroactive payments, receivables, or adjustments for prior periods.
- Different allocation methods: The financial statement may employ a different allocation method or base for certain expenses or other financial statistics.

COST CONTAINMENT PROGRAMS

WellSense has cost containment programs that focus on clinical programs and care and utilization management.

Clinical Programs

The areas of focus for each CM program include but are not limited to: keeping members healthy, managing members’ emerging risk, addressing member safety issues and concerns across various settings, and managing multiple chronic illnesses.

Additionally, WellSense has several medical management programs aimed at supporting individual member needs, such as health care education, disease management, population health management, transition of care, complex care management, and behavioral health services.

Medical Drug Management

Medical drug management (MDM) is a program designed to ensure the safe, effective and appropriate use of provider-administered medications. Provider-administered drugs include biologics, injectables, IVIG, and other drug products that cannot be self-administered by a patient or a care giver. As a result, they are infused or injected by a healthcare provider in a physician's office, outpatient hospital or other ambulatory setting. The MDM program incorporates claims edits and prior authorization requirements to ensure the appropriate utilization of medical drugs. The program aims to support high-quality patient care by promoting evidence-based prescribing, optimizing clinical outcomes and managing the rising costs associated with specialty and injectable therapies.

HealthCare Education

HealthCare education is a core activity targeting the general population as well as members identified with specific emerging risk or chronic illnesses. The educational materials consist of tools, and resources to promote wellness and prevention, and to provide new and easy ways for members to manage illness and stay healthy. Additionally, we offer multiple self-management programs such as chronic disease, chronic pain, diabetes and building better caregivers. Other topics include prevention activities related to childhood and adult immunizations, general nutritional tips, home and safety reminders, as well as condition specific education via traditional mailings, text messaging and online material.

Disease Management

Addresses chronic disease states, such as asthma and diabetes, and monitors the member's current status and provide education and outreach aimed at helping member understand their disease and the self-management they can do to optimize their health and safety.

Population Health Management

Addresses members with medical, behavioral, and social needs and interventions for specified diagnoses. This involves assessing the member's condition and/or emerging risk, coordinating care and services, and determining available benefits and resources, such as family support and community resources. An Individual Care Plan (ICP) is developed and implemented for the member, emphasizing psychosocial support, self-management goals, care coordination, ongoing monitoring, personal and home safety, and appropriate follow-up.

Transition of Care

This program targets members discharged from any setting throughout the healthcare continuum (emergency department, acute inpatient, and post-acute facilities). The Care Transition Program aims to meet the goal of mitigating unnecessary emergency department encounters and reducing inpatient readmission within 30 days of discharge. Through the member assessment and ICP, the program also aims to provide available benefit services and resources to keep the member in the least restrictive setting.

Complex Care Management (CCM)

The CCM program targets members with multiple complex illnesses, including those stratified as the highest risk and may include members with special health care needs. The program involves a multidisciplinary approach to assessing the member's clinical status and associated social determinants of health. The program emphasizes consensual face-to-face member meetings, coordination of care through the health care continuum, and determination of available benefits and resources including family support and community resources / partners.

Behavioral Health Care Management (BH CM)

WellSense offers support to our members with certain behavioral health conditions. Our behavioral health care coordinators are trained to help members with access to behavioral health services and can help with finding a behavioral health counselor and community resources near the member or explaining available treatment options.

WellSense also offers a Behavioral Health Enhanced Care Coordination (BH ECM) program to provide additional support. This is a care management program provided for WellSense members who are experiencing complex behavioral health or psychosocial conditions, sometimes in addition to medical concerns. BH ECM is a voluntary, flexible, short-term program to meet the individual needs and promote optimal behavioral health.

Utilization Management

WellSense performs utilization management for medical services such as inpatient stays and outpatient services. Additionally, WellSense performs pharmacy management, including prior authorization, quantity limits, step therapy, and formulary management.