RECENT UPDATES: MASSACHUSETTS (SMALL GROUP)

Health Care Reform Updates

2018 Requirement on Cost Sharing

Health and Human Services (HHS) through the 2018 Notice of Benefit and Payment Parameters establishes out-of-pocket maximum amounts based on two-year estimated premium adjustment percentages. The out-of-pocket maximum for in- network services for plans other than High Deductible Health Plans (HDHPs) for 2018 is $7,350 for self-only coverage and $14,700 for other than self-only coverage.

The IRS sets out-of-pocket maximum limits on High Deductible Health Plans (HDHPs). The HDHP limits for Tufts Health Plan Saver plans for 2018 are $6,650 for self-only coverage and $13,300 for other than self-only coverage. ACA rules limit out-of-pocket maximums on individuals within a family. In 2018, no one individual within a family can have an out-of- pocket maximum greater than $7,350.

Plan Benefit Changes

Effective upon renewal date on and after January 1, 2018 Tufts Health Plan is making a number of benefit changes to Massachusetts plans for small group employers. We are making these changes to help lower premiums for members and to better manage increasing pharmacy costs associated with new-to-market and specialty drugs.

These changes are explained below, and more detailed information will be shared in your renewal package that will include a plan comparison grid.

Deductible, Coinsurance & Out-of-Pocket Maximum

We have made changes to the deductible, coinsurance, and out-of-pocket maximum associated with some of our plans.

Prescription Drug

We have made changes to pharmacy copays for some of our plans. We encourage you to review our full Massachusetts drug formulary on our website to familiarize yourself with all tier and other prescription drug changes. This information is available on the Pharmacy page at www.tuftshealthplan.com.

Copayments

We have adjusted copays on some of our plans for primary care and specialist visits, urgent care, therapy services (physical, occupational and speech), testing (laboratory, diagnostic, and imaging), inpatient and outpatient procedures, and emergency services.

Durable Medical Equipment (DME)

Effective on a strike date of January 1, 2018, members will no longer be able to purchase oral enteral formulas at a retail pharmacy, and they will no longer be covered under the pharmacy benefit. Members will need to purchase these formulas from a contracted Durable Medical Equipment (DME) supplies provider. The cost share for medical supplies will apply, not the DME cost share.

Pediatric Dental

Effective on a strike date of January 1, 2018, your pediatric dental plan will be called *Delta Dental PPO.* This plan requires members to seek services from providers in the Delta Dental PPOSM network only. This plan does not cover dental services from Delta Dental providers who are outside of the PPO network or any out-of-network providers. For additional questions regarding this benefit or provider network, members should contact Customer Service at 1-844-260-6095, or by visiting http://www.deltadentalma.com/ppo-find-a-dentist/ and selecting *Delta Dental PPO*.

Your Choice Provider Re-Tiering

Effective January 1, 2018, our Your Choice plans will have updated provider tiering. This provider re-tiering includes both hospital tiering improvements and erosion. Please refer to our Provider Directory at www.tuftshealthplan.com for more information.

New Plans

Balanced Advantage is a plan that enhances member value by aligning cost share with the cost of the service, reflective in lower member cost shares in many instances. These plans also introduce site-of-service tiering, which encourages the use of low-cost and high-quality free-standing facilities through a lower cost share.

Essential Advantage is a plan that offers a simplified design at a competitive premium. On these plans, medical services track to a manageable deductible while pharmacy requires only a copayment. These plans can be used as a way to ease the transition to HSA-qualified plans (Saver), where all services apply to the deductible.

Advantage HMO Saver 3450 Bronze – offered beginning April 1, 2018

This is a high deductible health plan as defined by the Internal Revenue Service, and may be paired with an HSA. This particular Saver plan requires some member cost sharing after the deductible in the form of copayments, which we have lowered for several services when compared to previous similar plan designs.

Additional Information

Joint Surgery Management Program – effective January 1, 2018

To help improve clinical outcomes and manage the increasing cost of joint surgery, Tufts Health Plan, working in conjunction with an industry leader in medical specialty solution management, will provide utilization management for these services. We are providing this enhancement to our existing joint surgery program to help better manage utilization of elective surgeries and quality of care for our members.

Methadone Maintenance – Elimination of Member Cost-Share - effective upon renewal date on and after January 1, 2018

Recognizing the impact of the opioid crisis in the diverse communities we serve, we are taking steps to reduce barriers to the essential care our members need. The post-deductible copayment and cost share for methadone maintenance for all commercial plans are being eliminated.

New Member ID Cards to Be Issued

We will be issuing new member ID cards from May through April 2018 as employers renew to reflect updated administrative processes for out-of-area care. When a member receives care outside the Tufts Health Plan service area, the provider will refer to the respective logo on the back of the new ID card for billing purposes. The new ID cards will be mailed to members of all Massachusetts and Rhode Island based plans except for CareLink and Medicare plans. Also, Tufts Health Freedom Plan members will not receive new ID cards as part of this process.

Provider Directories

Provider directories are available to members online and through mobile devices at tuftshealthplan.com. Physical copies are available upon request.

Primary Care Provider (PCP) Designation

Massachusetts health plans are required by state law to attribute members to PCPs to the maximum extent possible. We record PCP designations for all HMO plan members and encourage PPO members to designate a PCP for which we'll also keep record. This designation does not change the administration of our PPO plans.

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, Tufts Health Plan covers the following procedures in connection with mastectomy for medically necessary conditions, including but not limited to breast cancer for men and women:

- Reconstruction of the breast affected by a mastectomy.
- Surgery and reconstruction of the other breast with the goal of producing a symmetrical appearance.
- Prosthesis and treatment of physical complications of all stages of mastectomy. (There is no annual dollar limit for breast prostheses coverage.)

Mandatory Medicare Reporting Requirements

Mandatory reporting requirements respecting Medicare beneficiaries have been created by the passage of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. By mandating electronic exchange of health insurance benefit entitlement information by responsible reporting entities (including Tufts Health Plan), these requirements will enable the Centers for Medicare and Medicaid Services (CMS) to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. To comply with this mandate, Tufts Health Plan will require employers to provide additional information to us, including member social security numbers and employer tax identification numbers. Our plan is to gather this information from our existing database wherever possible, and contact employers directly to supply us with necessary information to fill any gaps in our reporting requirements to CMS. For more information on this mandate, please contact your Account Manager.