RECENT UPDATES: RHODE ISLAND (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 in 2018, Tufts Health Plan is making a number of benefit changes to Rhode Island 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 with you 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. Please note that on PPO plans, the unauthorized (out-of-network) out-of-pocket maximum will now be three times the authorized out- of-pocket maximum.

Prescription Drug

We are introducing a new Generic Low Cost Copay program for all of our plans in 2018. A subset of generic drugs will now only require a new lower copay of $5. Other generic drugs not on this list will continue to require the higher Tier 1 copay. We have also made changes to pharmacy copays for some of our plans. We encourage you to review our full 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.

New Plans

We have created several new plans for 2018, including the *Essential Advantage*. 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.

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.

Telemedicine Coverage Act - January 1, 2018

Effective upon renewal or new sale on or after January 1, 2018, for all fully-insured Rhode Island based plans, health insurers shall provide coverage for the cost of health care services provided through telemedicine*, so long as the health care services would be covered when provided in person and are medically appropriate to be provided through telemedicine. Applicable deductible, copayment, or coinsurance will apply for a health care service provided through telemedicine.

**Telemedicine is the delivery of clinical health care services by means of real time two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.*

Non-Opioid Pain Treatment

In order to comply with recent changes to state law, effective January 1, 2018, all fully insured Rhode Island plans will include coverage for medically necessary evidence-based non-opioid treatments for pain for members with substance abuse disorders, including chiropractic care and osteopathic manipulative treatments. Applicable member cost-share will continue to apply

Infertility Coverage

In accordance with state law, effective August 1, 2017, all fully insured Rhode Island-based plans will provide coverage for standard fertility preservation services when medically necessary treatment may directly or indirectly cause iatrogenic infertility*. In addition, the requirement that a member be married to receive infertility services has been removed. Applicable member cost-share will continue to apply.

**Iatrogenic infertility is an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.*

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.

PCP Designation

Rhode Island law requires that health plans attribute members to primary care providers (PCPs). 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 coverage limit.

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.