



From the CEO

James Roosevelt, Jr.
President and Chief Executive Officer

Dear Valued Client:

I hope this Summer issue of Update finds you and your employees well. When it comes to offering a health plan to your employees, quality counts. We know that you want to offer your employees plans that provide quality coverage and access to the best health care providers and hospitals. I'm proud to be able to say that Tufts Health Plan—a local, nonprofit plan with a national reputation for excellence—is one of America's best.

I'm pleased to announce that the National Committee for Quality Assurance (NCQA) and *U.S. News & World Report* have once again recognized Tufts Health Plan's commitment to quality health care coverage and the health and well-being of our members. Please see page 7 to read about our Quality Report Card.

And in support of our commitment to the health and well-being of our members, I'm also excited to announce the launch of Destination Wellness, our guide for employers of any size to building a wellness program. As a pioneer in promoting a healthy workplace for employees, Tufts Health Plan is proud to share the knowledge we've acquired with you.

Tufts Health Plan wishes you a wonderful summer.

Sincerely,

James Roosevelt, Jr.
President and CEO

Incorporating Wellness Programs That Help Your Employees and Fit Your Budget

Health care costs are continually on the rise. Medical management programs have proven to be effective in controlling the growth of health care costs, but many employers are looking for other ways to impact the cost of health care for their employees. And many are looking towards company-sponsored wellness programs to help solve the problem.

You already understand that the health of your employees has an impact on your company's direct health care costs. The impact of your employees' health-risk factors and unhealthy behaviors can be substantial. For example, according to the Mayo Foundation for Medical Education and Research:¹

- Medical costs for smokers are 18% higher than costs for non-smokers
- Medical care expenses for employees who engage in no physical activity during an average week are approximately 5% higher than for those employees who are active at least one day per week.
- For those members of your workforce who are overweight, each one-unit increase in body mass index (BMI) costs an additional \$120 in medical expenses and \$83 in drug costs.

Add to these the fact that employees with health-risk factors also cost more in terms of absenteeism and lost productivity, and it's easy to see why wellness programs are a logical step in trying to control costs. It just makes sense to promote healthy behavior among employees by building wellness programming into your overall business strategy.

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Health and Human Services Temporary Reinsurance Program for Early Retirees and Their Dependents

As part of National Health Care Reform, the federal government has established a temporary reinsurance program for early retirees and their dependents. This program applies to those employer groups that offer health insurance coverage to early retirees. The Early Retiree Reinsurance Program will assist these employer groups with the cost of health care coverage.

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Changes to Impact Condition Programs—For Fully Insured Clients

Tufts Health Plan has implemented changes to our health management programs. These changes apply to all fully insured plans, with the exception of CareLinkSM plans.

Impact Conditions

Effective July 1, 2010, Tufts Health Plan will manage the impact conditions “in-house”:

- acid related stomach disorders
- back pain
- atrial fibrillation
- osteoarthritis

Healthways, Inc., a third-party vendor, has managed these programs for fully insured clients for the past several years.

Tufts Health Plan is moving toward a more targeted approach for health management by bringing these programs in-house. We are able to implement ongoing monitoring of affected members through claims data and, using evidence-based guidelines, facilitate needed intervention at the time it is identified on a more personal level. Our goal is to enhance

members’ care experiences and help them take active roles in managing their conditions.

- The Impact Condition programs will offer the following:
- Online information and self-help tools to provide details about the diagnosis
 - Online decision support tools to provide education about surgeries and treatment options
 - Case Management services connecting members with nurses at times of need
 - Provider and member care alerts to provide notification that Tufts Health Plan has identified a potential opportunity for care based on claims data

Please note that Healthways, Inc. will continue to manage these Impact Condition programs for self-funded clients.

If you have any questions, please contact your Account Manager.

Incorporating Wellness Programs That Help Your Employees and Fit Your Budget *(Continued from page 1)*

The Good News: Wellness Programs Are Not Just for Big Companies Anymore

Large employer groups have been among the first to embrace wellness programs, and much of the research on their impact on health care costs comes from these larger groups. But employer groups of all sizes can benefit from encouraging and promoting healthier lifestyles. And a wellness program does not have to have a big budget. There are many low-cost to no-cost wellness tools that can be incorporated that will have an impact on your employees.

Introducing Destination Wellness—A Practical Guide to Building a Wellness Program for Employers of Any Size

Putting together a Wellness Program does not have to be complicated—but it does require time and resources. Minimizing the effort and man-power required to get one off the ground inspired Tufts Health Plan to create **Destination Wellness**. Designed for employer groups of all sizes, Destination Wellness is your personal planning guide and provides:

- A step-by-step approach to make it easy to start a program in your company or refresh current programs
- Sample letters, templates, and posters conveniently available in hard copy and electronically
- Examples of how our own employees at Tufts Health Plan have benefited from wellness programs
- The Destination Wellness Toolkit, available in hard copy and also accessible at tuftshealthplan.com/destinationwellness

Destination Wellness has tangible information you need to start a company walking program, bring a Weight Watchers® meeting into the office, start a smoking cessation support group—and much more.

A Great Companion to Our Working Well Program

For many years, Tufts Health Plan has offered on-site wellness programs for groups with at least 50 employees. Through our **Working Well** program, our consultants analyze claims data (if available) and suggest programs that might positively impact the employee population. **Working Well** consultation continues to be an important part of the services that we offer to our employer groups. We see **Destination Wellness** as an extension of our employer wellness program offerings.

Call your Account Manager Today and Learn More About Destination Wellness

Destination Wellness is available to all Tufts Health Plan employer groups free of charge. To request more information on **Destination Wellness** and how you can put it to work for your employees, please call your Account Manager. You can also access the program on the Web at tuftshealthplan.com/destinationwellness.

¹“The True Cost of Poor Health.” www.mayoclinichealthsolutions.com. 2008. June, 2010 <http://www.hreonline.com/pdfs/05022008Extra_MayoCostOfHealth.pdf>.

Health and Human Services Temporary Reinsurance Program for Early Retirees and Their Dependents *(Continued from page 1)*

How the Program Works

The government is providing \$5 billion in financial assistance for this program. The program begins on June 1, 2010, and ends on the earlier of the exhaustion of the financial assistance or January 1, 2014. Employers must apply to the Department of Health and Human Services (HHS) to participate in the program.

Employers that are accepted into the program will receive reinsurance reimbursement for health benefit claims for retirees age 55 and older who are not eligible for Medicare, and for their spouses, surviving spouses, and dependents, regardless of age. Health benefits that qualify for relief include medical, surgical, hospital, prescription drug, and other benefits that may be specified by the secretary of HHS, as well as coverage for mental health services. The amount of this reimbursement to the employer is up to 80% of claims costs for health benefits between \$15,000 and \$90,000. Claims incurred between the start of the plan year and June 1 are credited towards the \$15,000 threshold for reimbursement. However, only medical expenses incurred after June 1, 2010 are eligible for reimbursement under this program.

Example:

An individual incurs costs of \$30,000 between the start of the plan year and June 1, and \$40,000 after that date. The amount that may be reimbursed is 80% of \$40,000 (or \$32,000)—the costs above the \$15,000 threshold that occur after June 1.

Notes: If a plan incurs \$90,000 or more in expenses before June 1, it is treated as having met the \$15,000 threshold and is eligible for reimbursement for costs incurred after June 1.

These limits apply and claims are filed for each individual's costs. Employers cannot add two or more individuals together to attain the threshold.

Application Process

Both self-funded and fully insured plans may apply, including plans sponsored by private entities, state and local governments, nonprofits, religious entities, unions, and other employers. Employer groups must complete and submit the application as directed by HHS (instructions are available at

the HHS Web site). At the time of this article's publication, further details regarding the application and submission were pending. However, through guidance given by HHS, we believe the application must include the following information:

- The projected amount of reimbursement to be received under the program for the first two plan year cycles with specific amounts for each plan year.
- An attestation that policies and procedures are in place to detect and reduce fraud, waste, and abuse.
- A description of the procedures or programs the plan sponsor has in place with the potential to generate cost savings with respect to chronic and high-cost conditions.
- An assurance that the plan sponsor has a written agreement with its health insurance issuer or group health plan to provide HHS with information necessary to verify compliance with the program requirements, including access to individually identifiable health information subject to the HIPAA Privacy Rule.
- A summary of how the plan sponsor will use reimbursed amounts to maintain its level of contribution to the plan and to reduce costs to the plan (e.g., using funds to lower participant deductibles, co-insurance, or copayments in future years).

Employers that have their applications approved thereafter must document and submit claims for reimbursement using procedures to be developed by HHS. Employers will be subject to audits to facilitate fiscal integrity.

Tufts Health Plan is available to assist our clients interested in participating in this program. If interested, we will provide an aggregate dollar amount representing medical claims incurred and paid through Tufts Health Plan from January 1, 2009, through May 31, 2010 for eligible members falling within the thresholds. Fully insured clients must have a minimum of 5 early retirees to receive this aggregate amount.

As more information becomes available, we will update you. If you are interested in obtaining the aggregate claims amount, or have questions related to this program, please let your Account Manager know. Your Account Manager may need information about your early retirees to process the claims report.

Genetic Information and Nondiscrimination Act (GINA) Interim Final Regulations

The Genetic Information and Nondiscrimination Act (GINA) was signed into law on May 21, 2008, to be effective for plan years beginning after May 21, 2009. Interim Final Regulations interpreting the law, published October 1, 2009, became effective for group health plans on the first day of the plan year beginning on or after December 7, 2009. (These regulations are considered final until the final regulations are published.)

GINA protects individuals against discrimination for health coverage and employment based on their genetic information.

The law prohibits health plans from using and disclosing genetic information for underwriting purposes, which include eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

GINA also prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment. Since Personal Health Assessments (PHAs) ask for family medical history, the law prohibits group health plans from requiring enrollees to complete a PHA prior to enrollment. It also prohibits group health plans from offering a financial incentive or other reward for completing a PHA.

Tufts Health Plan does not use genetic information for underwriting purposes, and, in compliance with GINA, will not ask members to complete a PHA prior to enrollment nor offer any incentives for members who complete a PHA.

Identity Theft—Protective Measures in Place

In 2009, the Massachusetts Office of Consumer Affairs and Business Regulation filed revised identity theft regulations that took effect March 1, 2010.

The regulations require that personal information (combinations of names along with Social Security numbers (SSNs), bank account numbers, and credit card numbers) be encrypted when stored on portable devices, or transmitted wirelessly or on public networks.

Tufts Health Plan is committed to the privacy and security of our clients and members. Please note that we are currently amending employer contracts to indicate that we are compliant with the regulations.

Patient Protection and Affordable Care Act

The recently passed Patient Protection and Affordable Care Act includes a provision that would extend coverage of dependents up to age 26. Implementation of this coverage is required to take effect upon new sale or renewal on or after September 23, 2010. Department of Health and Human Services Secretary Sebelius has asked insurers to voluntarily implement an extension of coverage in advance of the effective date of the law. You have probably seen in the news that several large insurance plans have voluntarily committed to extend coverage for dependents to age 26 before being required to do so by the health care reform law.

Tufts Health Plan has decided to extend coverage of dependents up to age 26, effective upon plan renewal beginning May 1, 2010 for all fully insured groups.

- For dependents who are currently covered under a family plan, coverage will continue uninterrupted until the dependent reaches the age of 26, regardless of your renewal date.
- For dependents who are **not** currently covered under a family plan but are younger than age 26, upon plan renewal on or after September 23, 2010, the dependent can be added back on the family plan until the age of 26.

Self-insured clients should work with their Account Managers to determine decisions related to implementation.

If you have questions, please contact your Account Manager.

In 2005, we converted member identification numbers from SSNs to random, system-generated numbers for the majority of our products. We have also taken some recent measures to become fully compliant with the regulations:

- We converted member identification numbers for commercial Medicare products (Tufts Medicare Complement (TMC) and Medicare Complement Plan (MCP)) from SSNs to random, system-generated numbers.
- Paper invoices no longer display printed SSNs; they now display member identification numbers.

If you have any questions, please contact your Account Manager.

New Special Open Enrollment Under CHIP

The Children’s Health Insurance Program Reauthorization Act of 2009 was signed into law on February 4, 2009. One part of this legislation created two additional special open enrollment rights for certain individuals to elect group health plan coverage.

Requirements for 2010

The law created annual employer notice requirements that will be effective starting in 2010. For plan year 2010, employers are required to provide notices by the later of:

- (1) The first day of the first plan year after February 4, 2010
- (2) May 1, 2010

For plan years beginning February 4, 2010, through April 30, 2010, the notice must be provided by May 1, 2010. For plan years beginning on or after May 1, 2010, the notice must be provided by the first day of the next plan year (January 1, 2011 for calendar year plans). The notice may also be provided concurrently with open enrollment materials or the benefit summary.

The Department of Labor has released a model notice for employers use, available at the Department of Labor Web site, dol.gov/ebsa/compliance_assistance, under the heading Children’s Health Insurance Program.

Background

Effective April 1, 2009, group health plans were required to allow employees and dependents who are eligible for but not enrolled in group health plan coverage to enroll for the following two additional situations:

1. The employee or dependent is eligible under a state Medicaid plan or state children’s health insurance program (CHIP) and the Medicaid or CHIP coverage is terminated. This loss of coverage allows the employee to request enrollment under the group health plan no later than 60 days after termination of the Medicaid or CHIP plan.
2. The employee or dependent becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP. The employee would need to request enrollment in the group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for the premium assistance subsidy.

If you receive requests from employees to add themselves or dependents under these new special enrollment rights, you should submit paperwork to Tufts Health Plan through the current process established for special enrollments.

Please contact your Account Manager with any questions.

High-Tech Imaging Upcoming Benefit Changes—Effective January 1, 2011

Tufts Health Plan will be implementing the following changes to plan benefits for high-tech imaging services, effective in 2011.

Upon plan renewal beginning January 1, 2011, for all HMO Premium, HMO Value, HMO Choice Copay, and HMO Basic plans, Tufts Health Plan will increase the copayment by \$25 for the following high-tech imaging procedures when they are performed in the outpatient setting:

- CT/CTA Scan
- MRI/MRA
- PET Scan
- Nuclear Cardiology

Important Note: Members will be exempt from paying the high-tech imaging copay when the imaging is required as part of an active treatment plan for a cancer diagnosis.

If you have any questions about these benefit changes scheduled for 2011, please contact your Account Manager.

Plan	Current Copayment	Copayment Effective January 1, 2011
HMO Premium	\$25	\$50
HMO Value	\$50	\$75
HMO Choice Copay	\$75	\$100
HMO Basic	\$100	\$125

COBRA Subsidy

This article describes COBRA subsidy options for employees. This information is amended from time to time, and the most recent news and forms are available at our Web site, tuftshealthplan.com.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010 (DOD Act) on December 19, 2009, the Temporary Extension Act of 2010 (TEA Act) on March 2, 2010, and the Continuing Extension Act (CEA Act) on April 15, 2010, provides certain assistance eligible individuals (AEIs) with a 65% premium subsidy to continue their group health plan coverage.

An AEI is a COBRA (or state continuation of coverage) qualified beneficiary who:

1. is involuntarily terminated from employment at any time from September 1, 2008, through May 31, 2010,
2. is eligible for COBRA or state continuation coverage, and
3. who elects continuation.

The law also includes income thresholds that prevent or limit a person's qualification for the subsidy.

The TEA Act extended subsidy eligibility through March 31, 2010. The TEA Act also provided subsidy to an AEI who was involuntarily terminated from employment from March 2, 2010, through March 31, 2010, following a qualifying event that was a reduction in hours that occurred at any time between September 1, 2008, and March 31, 2010. **Under the TEA Act, AEI's who are terminated following a reduction in hours were given a second election opportunity if they did not elect continuation coverage when it was first offered, or elected but subsequently discontinued continuation coverage.**

The CEA Act extended subsidy eligibility through May 31, 2010, including providing subsidy to an AEI who is involuntarily terminated from employment from March 2, 2010, through May 31, 2010, following a qualifying event that was a reduction in hours that occurred at any time between September 1, 2008, and May 31, 2010.

ARRA, as amended, mandates that plans notify certain current and former participants and beneficiaries about the premium reduction. For employer groups subject to COBRA, model notices are available on the Department of Labor's Web site. Each model notice is designed for a particular group of individuals and contains information to help satisfy ARRA's notice provisions, including those added by the DOD Act, the TEA Act, and the CEA Act.

The subsidy is provided in most cases by the employer or insurer, as clarified below. The subsidy is credited back to the employer or insurer through offsets to payroll tax payments. Please note: There is no premium subsidy available for periods of coverage that began prior to February 17, 2009.

For single employer groups that are subject to COBRA (employers with 20 or more employees), the employer is responsible for paying the subsidy. Tufts Health Plan will continue to bill these groups as usual, requiring payment in full for all active and COBRA continuation members.

For single employer groups subject to Massachusetts or Rhode Island continuation of coverage (employers with 2 through 19 eligible employees), Tufts Health Plan is responsible for paying the subsidy. Tufts Health Plan has provided guidance to these small employers, including employer attestations needed for Tufts Health Plan to administer the subsidy. Each month your invoice will reflect the full premium charge. Once the appropriate paperwork is received substantiating the subsidy, a credit adjustment will be posted on your next monthly invoice. The subsidy is available for Tufts Health Plan members with periods of coverage beginning on March 1, 2009. Consistent with usual practices, employer groups that do not pay the invoice balance in full will be terminated for non-payment of premium.

- The subsidy will end when the AEI:
- is eligible for coverage under any other **group** health plan; or
 - is eligible for benefits under Medicare; or
 - has exhausted his/her maximum period of COBRA or state continuation of coverage; or
 - is no longer enrolled in COBRA or state continuation of coverage; or
 - has received 15 months of premium subsidy.

The Department of Labor has released guidance and model notice language to assist employers with the notification requirements, available at dol.gov.

Information relating to the COBRA subsidy, including frequently asked questions, is available on the Internal Revenue Web site at irs.gov, and the Department of Labor Web site at dol.gov.

If you have questions, please contact your Account Manager.

Our Quality Report Card

The National Committee for Quality Assurance (NCQA) and *U.S. News & World Report* have ranked Tufts Health Plan, from among a field of some 487 participating health plans, third in the nation for our commercial HMO and POS products.*

In addition, our health plans hold the NCQA's highest Accreditations. NCQA is a private, nonprofit organization whose mission is to improve health care quality. NCQA and *U.S. News & World Report* awarded Tufts Health Plan five stars on an impressive array of quality measures. (Plans received ratings of 1 to 5 stars.)

* Commercial HMO and POS plans for 2009 and 2010. America's Best Health Plans 2009 – 10 is a trademark of *U.S. News & World Report*.

★★★★★	Member Satisfaction
★★★★★	Satisfaction with physicians
★★★★★	Personal doctor
★★★★★	Specialists
★★★★★	Care received
★★★★★	Satisfaction with health plan services
★★★★★	Prevention
★★★★★	Children and adolescents
★★★★★	Well-child visit, infants
★★★★★	Well-child visits for ages 3-6
★★★★★	Access for children ages 7-11
★★★★★	Adolescent well-care visits ages 12-21
★★★★★	Timeliness of prenatal checkups
★★★★★	Cancer screening
★★★★★	Breast cancer screening
★★★★★	Cervical cancer screening
★★★★★	Colorectal cancer screening
★★★★★	Early immunizations
★★★★★	Treatment
★★★★★	Diabetes
★★★★★	Blood pressure control (140/90)
★★★★★	Retinal eye exams
★★★★★	Glucose testing
★★★★★	Glucose control
★★★★★	LDL cholesterol control
★★★★★	Monitoring kidney disease
★★★★★	Heart disease
★★★★★	Beta blocker after heart attack
★★★★★	LDL cholesterol screening
★★★★★	Mental and behavioral health

New Online Member Health Centers

Our secure online member Web site, My Wellness Plan, offers tools and resources to help members manage their health, including Health Centers with specialized information on topics and conditions. We are pleased to introduce these new Health Centers in the Take Charge of My Health section:

Mental Health Center

When a member has been identified as needing mental health care, it can be challenging to find the right provider. Our Mental Health department is available to help members find an in-network provider that will meet their specific needs. The new Mental Health Center provides information about common mental health conditions, as well as contact information for our Mental Health department.

Asthma Health Center

People often don't realize that their asthma could be under better control. The Asthma Health Center offers an interactive tool for members to assess their asthma and work with their providers to improve their quality of life.

Back Health Center

About one-fourth of U.S. adults have back pain. Back pain and injuries are a significant source of absenteeism in the workplace. The Back Health Center focuses on preventing back pain and injuries, and managing back pain. The content includes interactive tools that help members assess their back pain, learn about treatment options, and make informed decisions about treatment.

Members can access these Health Centers by logging in at tuftshealthplan.com. If you have any questions, please contact your Account Manager.

MEMBER SERVICES

HMO/POS/EPO/PPO

800.462.0224

Tufts Health Plan Medicare Preferred

800.701.9000

SALES OFFICES

705 Mt. Auburn Street
Watertown, MA 02472
Phone: 800.208.8013
Fax: 617.923.5880

1441 Main Street, Suite 925
Springfield, MA 01103
Phone: 800.337.4447
Fax: 413.746.8300

102 Shore Drive, Suite 402
Worcester, MA 01605
Phone: 800.208.9545
Fax: 508.757.8311

One West Exchange Place
Providence, RI 02903
Phone: 800.455.2012
Fax: 401.272.1233

Announcing KeepingYouHealthy.com

A new resource for healthy local events, tips, discounts, and activities

We recently launched a dynamic social media site, KeepingYouHealthy.com, offering Massachusetts and Rhode Island residents an array of resources for healthy living. In addition to highlighting local events focused on health, discounts, tips, and seasonal activities, the site intends to create a community of individuals interested in healthy living who can offer ideas and support to one another.

Highlights of the site include:

- An Events and Activities Calendar that provides information on different types of programs and activities in the local area.
- Coupons and discounts for healthy activities and products
- An interactive health tips forum for users to post practical, everyday tips on health and wellness
- Articles on how to get more value from your health plan
- A library of videos on a variety of health topics

KeepingYouHealthy.com encourages user interaction and allows content to be shared on other social Web sites such as Facebook and Twitter. Users are eligible to win monthly prizes when their comments are posted on the site. In addition, audiences can follow KeepingYouHealthy.com on Twitter (@KeepingUHealthy) to get the latest updates on content.

For more information, visit <http://keepingyouhealthy.com>.