Tufts Associated Health Maintenance Organization, Inc.
Responses to Testimony Questions
September 16, 2013

Exhibit B: HPC Questions

1. C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

a. What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?

Summary: Tufts Health Plan's primary approach to mitigating the growth in Total Medical Expense (TME) is its Coordinated Care Model (CCM) which incorporates three elements that are necessary to encourage the delivery of cost effective care. These three elements include 1) value-based, global budget contract models that pay providers for their ability to manage the overall cost and quality of care, and include enhanced analytic and consultative support; 2) product designs that create aligned incentives for members and providers as they seek and direct care; and 3) clinical management programs that support providers who increasingly share employers' and government's goals of reducing health care cost trends.

Response:
Tufts Health Plan develops contracting strategies for provider negotiations with targets that have resulted in historically low unit cost levels in the past several years. Contract negotiations take into account a number of factors including a provider's reimbursement relative to the network and peer group, their ability to manage total medical expenses through alternative payment methods, the margins generated from Tufts Health Plan's reimbursement, a provider's overall quality relative to the network and peer group, among other factors. The aggregate unit cost targets plus expected utilization trends are benchmarked against the state's health care cost growth target of 3.6%.

In addition to the CCM approach, Tufts Health Plan has an internal Medical Trend Management (MTM) process which regularly monitors emerging medical trends and considers opportunities to mitigate these when appropriate. Through this process, a multi-disciplinary team conducts in-depth analyses of topics such as hospital readmissions, preventable initial admissions, emergency department overuse, behavioral health and oncology. As a way to address potential MTM opportunities, Tufts Health Plan regularly assesses existing, or develops new interventions in the areas of complex case management, disease management, health and wellness, utilization and level of care management, payment and medical policy, among other factors.

Lastly, Tufts Health Plan continues to focus on engaging consumers in health care decisions through product design and transparency. Product design includes a portfolio of high-deductible plans and tiered/limited network products. Solutions for transparency of cost and quality will be available to members starting in Q4 2013 and fully deployed in 2014. These solutions include a treatment cost estimator tool that provides estimates of total cost for health care services as well as out of pocket expenses based on a member's benefit design. Tufts Health Plan also plans to

further enhance the online provider search tool to allow members to search for providers based on overall cost, using standard measures such as relative price and total medical expense, and overall quality using a standard quality measure set.

b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?

Summary: Tufts Health Plan, through its Coordinated Care Model (CCM), has established many of the foundational elements to address opportunities that improve quality and efficiency of care. Several high impact opportunities that the CCM model focuses on include: (1) unwarranted variation in care, (2) site of service and provider differential in cost for clinically equivalent services, and (3) potentially avoidable Emergency Department visits, admissions and readmissions.

Response:
Tufts Health Plan addresses unwarranted variation in several ways – starting with benchmark reporting for value-based, global budget providers that includes variation in cost and utilization across a set of Episode Treatment Groups (ETGs). These reports highlight opportunities for improvement within care delivery systems and stimulate conversation with clinical leaders on ways to reduce ETG variation. For select procedures, where there is clinical evidence about the appropriate level of care, Tufts Health Plan also considers ways to reduce unwarranted variation through medical and payment policy that may be enforced through prior-authorization programs, claims edits and/or provider audits.

Mechanisms to address site of service and provider price differential include product design, steerage reports and cost and quality tools. Tufts Health Plan has developed a portfolio of products, including tiered, limited and deductible products that provide incentives for members to seek cost effective care. Steerage reports are provided to value-based, global budget providers to highlight opportunities to refer members to cost effective sites of service. Lastly, cost and quality transparency tools provide members with information required to make informed decisions on the value of care available.

Opportunities to address avoidable Emergency Department visits include promotion and education to members on alternatives to the Emergency Department for non-life threatening, urgent care needs when primary care providers are unavailable. Alternatives include Urgent Care Centers, Limited Service Clinics and the 24-Hour Nurse Line. In addition, Tufts Health Plan has a number of programs to address potentially avoidable admissions and readmissions including complex case management, disease management, health and wellness, utilization and level of care management, among others.

While we continue to make progress in addressing the aforementioned opportunities, there are a few factors which limit the full potential of these programs. (1) Consumer engagement continues to be a challenge. While Tufts Health Plan continues to develop various tools, increased engagement is necessary for members to manage their health and to make value-based decisions when seeking care. (2) Employer preference continues to be for full-network product options with some increased interest in tiered products but limited uptake of limited network products.

(3) As providers further adopt alternative payment methods that manage overall cost and quality of care, there needs to be increased focus on engaging staff at all levels of the delivery system – from senior leadership to front-line physicians and staff to maximize the potential and success of these arrangements.

c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?

Summary: There continues to be wide variation in the prices of similarly structured providers that are not based on quality. We believe these disparities will be perpetuated by further consolidation. It is important that Accountable Care Organizations (ACO) arrangements are fully evaluated to determine whether the consolidations will lead to better coordinated care and quality.

Response:
There continues to be wide variation in the prices of similarly structured providers that are not based on quality. We believe these disparities will be perpetuated by further consolidation. It is important that ACO arrangements are fully evaluated to determine whether the consolidations will lead to better coordinated care and quality.

In addition to reform changes there are a few areas that may be worth considering for policy to improve efficiency without compromising quality:

- Facility Fees: CMS currently allows physicians performing minor procedures at an "off-campus" setting, affiliated with a facility, to charge incremental facility fees. In such cases, physicians bill a professional and a facility claim, resulting in higher cost to the health plan and to consumers.
- Non-participating Providers: A significant percentage of Ambulance, Emergency Department physicians, Radiologists, Anesthesiologists and Pathologists, provide services without participating in contracts with health plans. Tufts Health Plan continues to work with facilities that utilize non-participating providers to encourage participation. However, there are limited incentives for providers to want to participate in a health plan's network for two main reasons: (1) they are typically able to charge higher rates for their services under a non-participating status, and (2) they have the ability to balance bill members if services are denied due to out-of-network requirements. Tufts Health Plan's approach has been to hold the member harmless from being balance billed and pays for claims from non-participating providers. However, there should be increased scrutiny placed on services provided by non-participating providers.
- Adoption of Choosing Wisely: The Choosing Wisely list, compiled by various medical societies, provides an opportunity to address medical tests and procedures that may be unnecessary, and in some instances can cause harm. Policy makers should consider systematic approaches for health care stakeholders to adopt this list and redesign care delivery appropriately.
- Market Consolidation: Tufts Health Plan continues to support evaluating the impact of and taking appropriate steps to control any negative implications associated with provider consolidation and undue provider market leverage.

d. **What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?**

Summary: Tufts Health Plan, through a variety of initiatives maintains a continuous focus on ways to reduce health care spending. These measures ensure that any reductions in health care spending are brought into our rates and passed along to consumers and businesses expeditiously and on an ongoing basis.

Response:
Tufts Health Plan, through its Coordinated Care Model (CCM), and the aforementioned initiatives, maintains a continuous focus on ways to reduce health care spending. Since Tufts Health Plan's rates are based on the most recent 12 months of claims experience projected forward using current trends, they inherently reflect changes in health care spending. Tufts Health Plan actuaries monitor claims experience on a monthly basis so that changes in trends are identified early and incorporated into pricing in a timely manner. In addition, anticipated savings from benefit changes, new clinical management programs and strategic initiatives are taken into account in the development of pricing trends, so that the impact of these programs is incorporated into our rates even before it emerges through claims. These measures ensure that any reductions in health care spending are brought into our rates and passed along to consumers and businesses expeditiously and on an ongoing basis.

2. **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?**

Summary: Addressing the growth in prices for medical care (i.e., unit cost increases) is the primary focus of Tufts Health Plan's contract strategy team as it works with individual providers to negotiate appropriate levels of reimbursements. These efforts have resulted in historically low unit cost levels in the past several years.

Response:
Addressing the growth in prices for medical care (i.e., unit cost increases) is the primary focus of Tufts Health Plan's contract strategy team as it works with individual providers to negotiate appropriate levels of reimbursements. Contract negotiations take into account a number of factors including a provider's reimbursement relative to the network and peer group, their ability to manage total medical expenses through alternative payment methods, the margins generated from Tufts Health Plan's reimbursement, a provider's overall quality relative to the network and peer group, among other factors. The aggregate unit cost targets plus expected utilization trends are benchmarked against the state's health care cost growth target of 3.6%.

Tufts Health Plan's Coordinated Care Model (CCM) provides the appropriate alignment of reimbursement, product design, and care management to promote and support efficient and cost-effective providers. Through our Provider Engagement Program available through the CCM, Tufts Health Plan shares comprehensive cost and utilization, referral pattern, practice pattern, quality performance, and medical management data on a regular basis with providers who are

reimbursed through risk-based contracts to help them direct care to more cost-effective providers. Tufts Health Plan's tiered and limited network product designs also provide financial incentives for value-based providers to work together to achieve patient-centered, high-value care in order remain in a more favorable tier to attract patients.

Tufts Health Plan's internal Medical Trend Management (MTM) process involves a multi-disciplinary team that monitors emerging medical trends and identifies trend drivers and sources of unit cost growth. The team regularly assesses existing or develops new interventions in areas such as complex case management, disease management, health and wellness, utilization and level of care management, and payment and medical policy to mitigate any areas of concern, when appropriate.

3. **C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?**

Summary: Tufts Health Plan first began working with providers for value in its commercial network over 15 years ago and has expanded value-based, global budget contract models to over 80% of its HMO membership. Tufts Health Plan supports value-based providers through a multi-pronged approach, referred to as the Coordinated Care Model (CCM), which integrates three elements that are necessary to support successful practice transformation to a "medical home" model. The integration of the support services available through the CCM along with value-based provider reimbursement, thoughtful benefit design, and clinical management programs create the right incentives for providers to align interests and deliver high-quality, efficient and coordinated care to patients as a cohesive team.

Response:
Tufts Health Plan believes that paying providers based on their ability to manage the overall cost and quality of care delivered to its members, instead of a fee-for-service basis, drives behavior change towards high-value care. Value-based contracts provide a key foundation to support the delivery of integrated, efficient, quality care. Tufts Health Plan first began working with value-based providers in its commercial network over 15 years ago and recognizes that successfully moving providers from traditional fee-for-service to value-based payment does not end with the signing of the contract. Tufts Health Plan has developed the Coordinated Care Model (CCM) to assist and support providers as they undertake payment and practice transformation to move towards achieving the triple aim of 1) improving the patient experience of care; 2) improving population health; and 3) reducing the cost of health care.

Tufts Health Plan's CCM incorporates three elements that are necessary to encourage the integration of provider organizations in global payment arrangements. These three elements include 1) value-based, global budget contract models that pay providers for their ability to manage the overall cost and quality of care, and include enhanced analytic and consultative support; 2) product designs that create aligned incentives for members and providers as they seek and direct care; and 3) clinical management programs that support providers who increasingly share employers' and government's goals of reducing health care cost trends.

As part of the CCM, Tufts Health Plan has expanded value-based, global budget contract models to over 80% of its HMO membership. These models provide aligned incentives for providers and payers to collaborate in delivering more efficient, higher quality care. Tufts Health Plan has also developed a Provider Engagement Initiative which supports providers in global payment arrangements through detailed reporting of cost and quality results, customized analytics, and clinical consultation. Comprehensive data analysis is shared with providers on a quarterly basis, encompassing cost and utilization benchmarking, referral pattern assessment, practice pattern variation analysis, quality performance, and medical management outcomes. It is important to note that every provider group is unique in their support needs for practice transformation, and so highly customized additional analyses are routinely designed for groups based on analytical findings and provider areas of interest. When potential opportunities to improve quality or efficiency are identified through these analyses, subject matter experts from Tufts Health Plan with clinical or analytical expertise work collaboratively with the provider group to understand these opportunities and develop tangible action steps to address them. These quarterly analyses are supplemented by a number of standard Tufts Health Plan provider reporting resources, including daily pre-registration reports, full claims extracts, and regular case management reports.

A second goal of the CCM is to promote coordination of care through innovative product design. Tufts Health Plan's tiered network products include the full Tufts Health Plan network of providers, but provide financial incentives to encourage members to select high-value providers and pursue healthy lifestyles. Tufts Health Plan's Your Choice tiered network product is unique in this market, as it tiers at the provider organization level, rather than at the individual physician level. Maintaining PCPs and the specialists and hospitals to which they typically refer on the same tier leads to a better member experience. Additionally, tiering at an organization level allows Tufts Health Plan to reinforce the efforts of provider organizations in value-based contracts to maintain care within their systems, thereby enhancing clinical integration.

Finally, Tufts Health Plan's clinical management programs support providers in global payment contracts by helping practices deliver the right care to the right people at the right time. Tufts Health Plan identifies members for risk-stratified care management programs by applying proprietary identification and classification algorithms to claims data to predict risk. Intervention plans are tailored to the needs of each patient based on clinical risk stratification, educational needs, and readiness to change. Participants are continuously re-stratified each time new data become available through claims or direct patient contact, allowing members to move seamlessly between interventions and program types based on their ever-changing health condition and the clinical needs. In addition to provider specific support, Tufts Health Plan has an internal Medical Trend Management (MTM) process which regularly monitors emerging network-wide medical trends and considers opportunities to mitigate these when appropriate. Through this process, a multi-disciplinary team conducts in-depth analyses of topics such as hospital readmissions, preventable initial admissions, emergency department overuse, behavioral health and oncology. As a way to address potential MTM opportunities, Tufts Health Plan regularly assesses existing or develops new interventions in the areas of complex case management, disease management, health and wellness, utilization and level of care management, payment and medical policy, among others.

The integration of the support services available through the CCM along with value-based provider reimbursement, thoughtful benefit design, and clinical management programs create the right incentives for providers to align interests and deliver high-quality, efficient and coordinated care to patients as a cohesive team.

As providers further adopt alternative payment methods that manage overall cost and quality of care, there needs to be increased focus on engaging staff at all levels of the delivery system – from senior leadership to front-line physicians and staff to maximize the potential and success of these arrangements.

4. **C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.**

Summary: Members enrolled in both the Tufts Health Plan Medicare Preferred and Commercial HMO and POS products are required to select a primary care provider (PCP) as part of the enrollment process. With the exception of select self-insured employer accounts which require PCP selection by their enrollees, most Commercial PPO members are not required to select a PCP. Our approach is to educate Commercial PPO members on the importance of a PCP and encourage PCP selection through various collection channels. The member's designated PCP is stored in the member's enrollment record.

Response:
Members enrolled in both the Tufts Health Plan Medicare Preferred and Commercial HMO and POS products are required to select a primary care provider (PCP) as part of the enrollment process. With the exception of select self-insured employer accounts which require PCP selection by their enrollees, most Commercial PPO members are not required to select a PCP. Although not critical for referral management, Tufts Health Plan believes there is value in having an assigned PCP. Tufts Health Plan believes, however, that members should actively select their own PCP versus be passively assigned to practice groups via attribution methodology. As a result, our approach is to educate Commercial PPO members on the importance of a PCP and encourage PCP selection through various collection channels. The member's designated PCP is stored in the member's enrollment record.

Tufts Health Plan continues to explore the use of attribution methodology for the PPO population based on historical claims experience. The Massachusetts Health Quality Partners (MHQP) has developed a PPO attribution model that several payers, including Tufts Health Plan, use for patient attribution in patient-centered medical home pilot programs. One challenge with using claims experience to attribute PPO members to providers is the inability to attribute members without sufficient claims experience.

5. **Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?**

Summary: Tufts Health Plan employs a number of strategies to encourage the use of more cost effective care settings and providers. These strategies include benefit and network design, provider incentives, and cost transparency.

Response:
Recognizing that delivery of care in more expensive settings may contribute to health care cost inflation; Tufts Health Plan's Coordinated Care Model (CCM) encompasses a number of strategies to encourage members to seek care in more cost effective settings. These strategies include benefit and network design, provider payment incentives, and tools to help members navigate the health care system.

One set of strategies involves benefit and network design. Tufts Health Plan offers several product options with a more select network of providers and limited access to tertiary care facilities. We also offer a suite of products with reduced cost sharing for primary care versus specialist care visits. Finally, members of Tufts Health Plan's Navigator and Your Choice tiered network products pay lower copayments for services provided by primary care physicians, specialist physicians and acute care hospitals that perform favorably on a set of widely accepted quality and efficiency measures.

Tufts Health Plan's limited and tiered network products provide employer groups with meaningful premium cost savings relative to traditional full network products with equivalent member cost sharing, typically averaging 10-15%. Given that the emergence of these products is a relatively recent market development, it is too early to determine how these premium differentials might shift over the long term.

A second set of strategies to encourage members to seek care in more cost effective settings involves provider payment incentives. Most provider groups within Tufts Health Plan's HMO network assume full or partial budget risk for the members in their care. These provider groups have a clear financial incentive to control the volume of care delivered in more expensive settings. Other provider groups within our HMO network participate in Tufts Health Plan's pay for performance program, which for some providers includes a measure of the percentage of hospital admissions that are retained at the group's home hospital. Under this program, providers can receive a bonus or a higher rate increase if the percentage of admissions to their home hospital, versus a more costly facility outside their referral network, reaches a given threshold.

Finally, Tufts Health Plan aims to encourage members to seek care in more cost effective settings through greater transparency of cost and quality information. Through Tufts Health Plan's secure member web portal, members have access to hospital quality and cost data for a wide variety of common admissions and procedures. Members also have access to several treatment decision support tools that describe treatment options and present information on outcomes. The use of this information and tools by members continues to grow, and their availability allows members to make more informed choices.

6. **Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network**

affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.

Summary: The Massachusetts market continues to experience a significant amount of provider consolidation. These consolidations may provide, in the long term, an opportunity for increased efficiency from clinical and financial integration as systems grow in size and become fully-deployed Accountable Care Organization (ACO). There is, however, a more immediate concern about growth in unit costs as smaller, less leveraged physician group or hospitals join forces with larger, more leveraged systems. History has demonstrated that larger provider groups may leverage their position to exert higher rates as a result of bundled negotiation by the systems.

Response:
Tufts Health Plan strives to achieve the lowest reimbursement rates consistent with quality care for all provider negotiations. We also strive to create contracting relationships in which providers have an aligned incentive to reduce total medical expense. This is achieved through the development of appropriately structured value-based contracts. Despite these goals, Tufts Health Plan recognizes that similarly situated providers may receive different rates of reimbursement. These differences are driven by a variety of factors, including provider group consolidation.

The Massachusetts market continues to experience a significant amount of provider consolidation. These consolidations may provide, in the long term, an opportunity for increased efficiency from clinical and financial integration as systems grow in size and become fully-deployed ACO. However, in the immediate future, provider consolidations generally have an inflationary impact on unit costs, as smaller physician groups or hospitals seek rates that are on par with the larger, more leveraged systems they have joined. One recent hospital consolidation resulted in a 40% one-time increase in unit costs for the provider joining the larger system, and a recent consolidation of physician groups increased unit costs for the physicians joining the larger system by 19% (over the course of the contract). This inflationary impact may persist as the new, larger provider system may leverage their position to exert higher rates in future negotiations.

Greater price transparency has also changed provider relationships and impacted our medical trends over the past three years. While greater price transparency has the potential to mitigate long term cost trends, the near term impact of transparency could contribute to increasing cost trends, as lower-paid providers exert pressure on payers to close the gap with higher paid providers through increased reimbursement rates. Market consolidation exacerbates this dynamic, as lower paid providers seek rates of increase comparable to peers within their geographic area who have joined with a larger, more leveraged system.

It is important to point out that we have limited flexibility to exclude providers if they are not willing to accept lower rates. Larger integrated health care systems tend to have greater leverage in negotiations since the level of disruption to our members is greater if we fail to reach agreement. While there is increasing demand from certain employers and customers for limited network products, the majority of our customers continue to exert significant pressure on Tufts Health Plan to include all providers in the network.

7. **Please describe the steps that your organization has taken and will be taking to provide consumers with cost information for health care services, including the allowed amount or**

charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224.

Summary: Tufts Health Plan has taken numerous steps to provide consumers with cost information for health care services including partnering with Castlight Health, an organization experienced in healthcare transparency, to offer a treatment cost estimation tool that will provide members with the ability to shop for providers by service, cost and quality.

Response:
Tufts Health Plan has partnered with Castlight Health, an organization experienced in healthcare transparency, to offer a treatment cost estimation tool that will provide members with the ability to shop for providers by service, cost and quality. Cost estimates will be member specific and calculations will include the member's personal plan and benefit information, deductibles already paid for the year and other member specific information where appropriate. The tool will be available to all commercial members through a link on the Tufts Health Plan member portal, 800 number and via mobile devices.

The Castlight Health tool will develop cost estimates for treatments using Tufts Health Plan claims, eligibility, plan benefit, account accumulator and provider data. The tool will allow commercial members to search for treatments and providers, review cost and quality of the providers and add patient reviews. Tufts Health Plan's targeted launch date for the Castlight tool is first quarter of 2014.

Beginning October 1, 2013, Tufts Health Plan members will be able to request an estimate of cost and associated out of pocket expenses attributed to the treatment and or services requested via the Tufts Health Plan Member Portal, inputting information on a web based form to be delivered by email or by using a toll free telephone number. Member Services staff will work directly with the member and internal Tufts Health Plan departments to confirm benefit information and correct pricing data to provide members with most accurate information available at the time of the request. Members will receive a response within two days of the request by telephone or email, followed by a written summary of their cost estimate.

8. **After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.**

Summary: For the most part, our business results are consistent with the AGO and CHIA 2013 reports.

Response:
Tufts Health Plan's results are consistent with several of the findings of the AGO and CHIA 2013 reports. In terms of product and membership results, we have seen an increase in the take-up rate of high deductible plans, a modest increase in PPO and indemnity plans for the fully-insured and self-insured Commercial large group segments and a very slight decline in the HMO/POS plan type as depicted in table 2c. Similarly, our 2012 year end results show in increase in tiered network products and a very modest increase in limited network products. Although Tufts Health Plan has offered a limited network product since 2007, growth has been

slow, particularly in the eastern part of the state, due to the consumer demand for a full network plan.

In terms of contractual arrangements and payments to providers, Tufts Health Plan's own results support the findings of the AGO and CHIA with regard to the disparity and variation in payments. Our contracting efforts continue to be focused on mitigating unit cost growth, while at the same time, transitioning our network to value-based, global budget contracts that focus on total medical expense. Although we have made significant progress implementing value-based contracts, these arrangements are typically limited to our HMO fully-insured membership and products. However, as we mention in other sections, we have started working with select providers to share risk for a subset of our self-insured membership.

Despite these efforts and collaborations, we continue to see variation in total medical expense among providers and across geographic regions. We are striving to reduce these variations through our Coordinated Care Model by focusing on value-based reimbursement that mitigates the growth in total medical expense, product and transparency solutions that steer members towards value-based services and care management programs to improve the health status of our members.

We have not experienced, with our own contractual arrangements, an increase in the assumption of insurance risk by our contracted network. As referenced in other sections, Tufts Health Plan's commercial value-based contracts typically include a number of protections designed to hold providers harmless for insurance risk.

Exhibit C: Questions from OAG

1. **Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).**

Summary: Below is Tufts Health Plan's summary table showing actual observed allowed medical expenditure trends in Massachusetts for the specified time periods.

Response: On average, the aging of the population adds about 1% to trend annually, while the health status of the population increases on average by about 2% per year. The impact of these changes (which are not mutually exclusive) is seen primarily in the utilization trend. While Tufts Health Plan has observed a slight deceleration in the rate of benefit buy-down in recent quarters, there was a significant movement of membership into high deductible plans (without HSA) between 2009 - 2013 (see AHMO Membership chart below for supporting detail), which may have been a factor in suppressing utilization trends during that time.

Exhibit C1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure **Trend by Year**

Fully Insured HMO Product ONLY

	Medical FFS				Pharmacy			Medical FFS + Pharmacy				Total
	Unit Cost	Utilization	Mix	Total	Unit Cost/Mix	Utilization	Total	Unit Cost/Mix	Utilization	Total	Non-Claim	Claim + Non Claim
CY 2010	5.1%	-0.8%	0.2%	4.5%	-3.9%	1.8%	-2.2%	2.9%	0.4%	3.3%	12.8%	3.9%
CY 2011	4.3%	-0.5%	-1.2%	2.5%	2.3%	1.1%	3.5%	2.4%	0.3%	2.6%	16.9%	3.6%
CY 2012	3.2%	1.9%	-0.9%	4.2%	-5.2%	2.4%	-2.9%	0.8%	2.1%	3.0%	6.5%	3.2%
YE Q1 2012 (April 1, 2011 - March 31, 2012)				3.1%			4.9%			3.4%		
YE Q1 2013 (April 1, 2012 - March 31, 2013)				3.6%			-7.4%			1.7%		

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix changes. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.
2. PROVIDER MIX is defined as the impact on trend due to the change in the types of providers. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

Advantage HMO Membership[1]

Q1 2007 – Q1 2013

YrMth	Avg HMO Members	Avg AHMO Members	AHMO %
2007Q1	231,036	11,613	5.0%
2007Q2	236,185	16,469	7.0%
2007Q3	240,985	20,917	8.7%
2007Q4	246,810	23,864	9.7%
2008Q1	252,629	26,759	10.6%
2008Q2	255,363	29,689	11.6%
2008Q3	261,618	34,572	13.2%
2008Q4	263,798	38,730	14.7%
2009Q1	257,657	48,110	18.7%
2009Q2	254,403	60,444	23.8%
2009Q3	256,894	70,210	27.3%
2009Q4	260,826	80,344	30.8%
2010Q1	260,337	98,241	37.7%
2010Q2	259,670	111,215	42.8%
2010Q3	258,046	116,442	45.1%
2010Q4	258,181	123,082	47.7%
2011Q1	254,386	128,392	50.5%
2011Q2	251,839	132,068	52.4%
2011Q3	254,574	133,521	52.4%
2011Q4	253,429	132,314	52.2%
2012Q1	250,649	130,840	52.2%
2012Q2	246,543	129,474	52.5%
2012Q3	244,085	128,428	52.6%
2012Q4	244,264	128,828	52.7%
2013Q1	238,951	127,679	53.4%

[1] AHMO membership has increased significantly as a proportion of total HNO membership. Membership has grown from 5.0% in Q1 2007, to 53.4% in Q1 2013.

2. **Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:**

a. Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)

2.a Members by Market Segment[1]

Market Segment	2009	2010	2011	2012
Medicare[2,3]	92,875	94,709	108,006	116,455
Medicaid				
Other Government	91,397	93,336	91,299	106,131
Commercial Large Group	297,706	291,095	280,553	268,232
Commercial Small Group	98,026	96,942	93,302	85,997
Commercial Individual	3,647	6,108	6,345	7,463
Total	583,651	582,190	579,505	584,278

[1] Membership recorded at year end

b. **Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that do not subject the provider to any "downside" risk; hereafter "risk contracts")**

2.b Members by Risk Contract[1]

Market Segment	Risk Contract	2009	2010	2011	2012
Medicare[2,3]	Y	71,483	75,269	76,568	83,787
	N	21,392	19,440	31,438	32,668
Medicaid	Y				
	N				
Other Government	Y	0	0	0	0
	N	91,397	93,336	91,299	106,131
Commercial Large Group	Y	70,869	73,571	101,008	142,345
	N	226,837	217,524	179,545	125,887
Commercial Small Group	Y	29,009	32,169	42,771	62,167
	N	69,017	64,773	50,531	23,830
Commercial Individual	Y	659	1,000	1,918	4,221
	N	2,988	5,108	4,427	3,242
Total		583,651	582,190	579,505	584,278

[1] Membership recorded at year end
[2] Includes membership in Medicare and Medicare-related products (e.g. Medicare Supplement and Medicare Complement plans).
[3] Medicare Segment includes government members in Medicare products.

c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)

2.c Members by Product line[1]

Market Segment	Product	Insurance Arrangement	2009	2010	2011	2012
Commercial Large Group	HMO/POS	Fully-insured	150,109	143,605	142,582	138,846
		Self-insured	102,055	97,716	84,211	71,179
	PPO/Indemnity	Fully-insured	13,343	14,749	15,331	17,019
		Self-insured	32,199	35,025	38,429	41,188
Commercial Small Group	HMO/POS	Fully-insured	93,652	93,455	90,551	83,670
		Self-insured	0	0	0	0
	PPO/Indemnity	Fully-insured	4,374	3,487	2,751	2,327
		Self-insured	0	0	0	0
Commercial Individual	HMO/POS	Fully-insured	3,532	5,919	6,156	7,185
		Self-insured	0	0	0	0
	PPO/Indemnity	Fully-insured	115	189	189	278
		Self-insured	0	0	0	0
Total			399,379	394,145	380,200	361,692

[1] Membership recorded at year end

d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)

2.d Tiered Network Product Members by Market Segment[1,4,5]

Market Segment	2009	2010	2011	2012
Other Government	80,586	81,994	79,896	94,125
Commercial Large Group	18,566	21,931	24,437	35,415
Commercial Small Group	0	0	370	742
Commercial Individual	0	0	0	0
Total	99,152	103,925	104,703	130,282

[1] Membership recorded at year end
[4] Designated Provider Organization (DPO) members are not included in the Tiered Network Product member counts.
[5] Members in a product with a limited and tiered provider network are reflected in both Tables 2d and 2e.

e. **Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)**

2.e Limited Network Product Members by Market Segment[1,5]

Market Segment	2009	2010	2011	2012
Other Government	0	1,036	6,219	6,362
Commercial Large Group	0	0	0	50
Commercial Small Group	680	962	1,061	1,072
Commercial Individual	1,432	3,045	1,890	1,353
Total	2,112	5,043	9,170	8,837

[1] Membership recorded at year end
[5] Members in a product with a limited and tiered provider network are reflected in both Tables 2d and 2e

f. **Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations)**

2.f High Deductible Health Plan Members by Market Segment[1]

Market Segment	2009	2010	2011	2012
Other Government	0	0	0	0
Commercial Large Group	1,197	2,976	3,441	4,042
Commercial Small Group	714	955	1,348	1,247
Commercial Individual	54	400	559	734
Total	1,965	4,331	5,348	6,023

[1] Membership recorded at year end

3. **To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.**

Summary: Overall, from 2009 – 2012 Tufts Health Plan Medicare membership has been gradually increasing, while the Commercial membership has been gradually decreasing

Response:
Overall, from 2009 – 2012 Tufts Health Plan Medicare membership has been gradually increasing, while the Commercial membership has been gradually decreasing. Key trends to note during this period include:

- A growing proportion of self-insured members within the Large Group segment
- Noticeable growth in the number of Commercial members falling under risk contracts, which is consistent with Tufts Health Plan's contracting strategy during that time, and the increasing willingness of providers to take on risk
- Moderate growth in the tiered and limited network products

4. **Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g., HMO, PPO, self-insured, fully insured).**

Summary: Tufts Health Plan has significant experience administering alternative payment methods through its Medicare Preferred and Commercial products. The reimbursement model for Tufts Health Plan Medicare Preferred consists of a federally funded capitated payment established by the Center for Medicare & Medicaid Services (CMS) and a supplemental member premium.

Tufts Health Plan has similar value-based arrangement for the Commercial HMO fully-insured book of business. The standard commercial value-based contract is a multi-year arrangement that establishes an annual, global per member per month (PMPM) budget to manage total medical expense for members on a PCP panel.

Response:
Tufts Health Plan believes that a fundamental change in the way providers are reimbursed is key to mitigating the escalating cost of health care. For this reason, a critical component of Tufts Health Plan's Coordinated Care Model (CCM) involves paying providers for value, or based on their ability to manage the overall cost and quality of care delivered to our members. Value-based contracts provide a key foundation to support the delivery of integrated, efficient, quality care. However, switching to such a payment structure in of itself is not the total solution. If a provider is paid on a yearly budget basis, but the budget is allowed to increase at levels well above general inflation, we have not necessarily accomplished behavior change and cost containment goals.

Tufts Health Plan has significant experience administering alternative payment methods through Tufts Health Plan Medicare Preferred and Commercial products. The reimbursement model for Tufts Health Plan Medicare Preferred consists of a federally funded capitated payment established by the CMS and a supplemental member premium. Through this reimbursement structure, a PMPM budget is established for participating providers. Actual performance is tracked against the medical budget and providers can earn a surplus or a deficit based on their ability to manage overall cost for patients on their PCP panel. A large portion of providers under this reimbursement structure have achieved performance levels that manage costs below the PMPM budget. In addition, Tufts Health Plan's Medicare Preferred product has consistently earned high quality rankings (4.5 out of 5) through the CMS star system which tracks quality measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the health outcome survey.

Tufts Health Plan has also established similar value-based arrangement for the Commercial HMO fully-insured book of business. These arrangements have been in place for several years for a small portion of our network but have increased in adoption over the past three years, with over 80% of our HMO membership on value-based contracts for 2013, up from less than 20% covered under value-based arrangements in 2009. Although the structure of Tufts Health Plan's

value-based contracts varies depending on the circumstances and capabilities of each provider organization, the standard contract is a multi-year arrangement that establishes an annual, global PMPM budget to manage total medical expense for members on a PCP panel. The annual budget, typically is established based on historic total medical expenditures (TME) trends for that provider organization with prospective increases (or decreases) in the budget trend based on negotiation factors, though some arrangements tie the budget target to an incremental improvement over TME trend for the entire network. Providers can earn a share of the surplus if they effectively manage cost below the budget, or pay a share of the deficit if they exceed it. Generally, the surplus or deficit share that tracks to the provider organization is 50% or more. In addition, a provider's performance and effectiveness is associated with quality metrics (e.g., HEDIS, Joint Commission, Leapfrog, National Quality Forum, CAHPS, clinical grievances, quality of care occurrences, credentialing, medical record review, member satisfaction surveys, health outcomes assessments, functional outcomes assessment, program evaluation, and process engineering) that allow providers to earn a larger portion of the surplus or decrease their deficit exposure based on quality outcomes in order to guard against any deterioration in quality and underutilization that may place members at risk.

Tufts Health Plan's commercial value-based contracts typically include a number of protections designed to hold providers harmless for insurance risk. The first of these protections is a mechanism where provider budget targets are severity adjusted to reflect the underlying health of the provider's patient population. Using proprietary software, severity adjustment allows us to address the concern that providers may be inappropriately advantaged or disadvantaged by caring for a cohort of patients that are not representative of our membership as a whole. Second, we generally exclude from provider budget targets several categories of spending that are inherently volatile. Costs related to members with significant medical needs or out-of-area expenses, for example, can vary substantially from year to year, even when such services are well managed. Finally, many of our value-based contracts include per member per month caps on potential provider deficits. These caps are intended to give providers, who are not required to meet the financial reserve standards established for health plans, adequate protection against catastrophic consequences stemming from medical cost changes that may or may not be within their control. The dollar value of these caps, and the share of risk assumed by providers in value-based contracts, is calibrated during the negotiation process to reflect the provider's ability to manage medical costs and quality under these arrangements. Providers, particularly those with higher levels of risk, may choose to purchase stop-loss from a third party reinsurance carrier.

5. **Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.**

Summary: For fully-insured HMO business, Tufts Health Plan's contracting strategy is to share performance risk with providers, while retaining insurance risk. We consider insurance risk to be those costs that a provider would have no reasonable ability to manage effectively. These protections include severity adjustment of budget targets, exclusion of certain categories of

medical cost from risk, and provider liability caps. Historically, we have not formally shared risk with providers for self-insured membership; however, in 2013, we have started working with select providers to share risk for a subset of our self-insured membership, which will help us evaluate our contracting strategy for this book of business.

Response: For fully-insured HMO business, Tufts Health Plan's contracting strategy is to share performance risk with providers, while retaining insurance risk. We consider insurance risk to be those costs that a provider would have no reasonable ability to manage effectively.

Tufts Health Plan's value-based contracts typically include a number of protections designed to hold providers harmless for insurance risk. The first of these protections is a mechanism where provider budget targets are severity adjusted to reflect the underlying health of the provider's patient population. Using proprietary software, severity adjustment allows us to address the concern that providers may be inappropriately advantaged or disadvantaged by caring for a cohort of patients that are not representative of our membership as a whole. Second, we generally exclude from provider budget targets several categories of spending that are inherently volatile. Costs related to members with significant medical needs or out-of-area expenses, for example, can vary substantially from year to year, even when such services are well managed. Finally, many of our value-based contracts include PMPM caps on potential provider deficits. These caps are intended to give providers, who are not required to meet the financial reserve standards established for health plans, adequate protection against catastrophic consequences stemming from medical cost changes that may or may not be within their control. The dollar value of these caps, and the share of risk assumed by providers in value-based contracts, is calibrated during the negotiation process to reflect the provider's ability to manage medical costs and quality under these arrangements.

While Tufts Health Plan aims to include elements of the protections described above in most of our value-based provider contracts, provider capacity to assume financial risk varies significantly. Accordingly, value-based contract terms and financial protections also vary significantly, depending on a number of factors. These factors include the provider's size and membership, degree of alignment between hospitals and physicians, level of clinical integration, and financial strength.

The value-based contract elements described above apply to reimbursement arrangements for Tufts Health Plan's fully-insured HMO membership. Historically, we have not formally shared risk with providers for self-insured membership; however, in 2013, we have started working with select providers to share risk for a subset of our self-insured membership, which will help us evaluate our contracting strategy for this book of business.

6. **Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.**

Summary: Tufts Health Plan has general criteria for assessing a provider's ability to participate in a risk contract. While we do not dictate particular levels, we determine a provider's overall

capacity to manage risk and try to understand the provider's objectives for entering into such arrangement.

Response:
Tufts Health Plan has general criteria for evaluating the capacity of a provider to participate in a risk contract. These criteria are not intended to be prescriptive, but do provide a sense for the type of contractual arrangement that is most appropriate for a given provider organization.

- *Provider Size.* Provider groups should have a sizable panel to enter into risk contracts. Approximately 2,000 to 3,000 members associated with a provider's panel provide sufficient volume assuming appropriate risk protections are in place. Smaller groups are subject to a high level of volatility in patient severity and may not be able to control total cost under a risk contract.

- *Physician/Hospital Alignment.* Physician and hospital alignment is a critical element for a provider's ability to optimize performance under value-based contracts. To effectively manage overall cost and quality for a large PCP panel, physicians and hospitals have to appropriately structure funds flow and be aligned to deliver integrated, cost effective, quality care. This alignment is most effective if care redesign objectives are established across the organizations.

- *Clinical Integration.* Clinical integration is also a key element for a provider's ability to optimize performance under value-based contracts. Clinical integration may refer to the systems (e.g., Electronic Medical Records, Computerized Physician Order Entry) in place that enable patient-centered communication amongst the clinical teams. It may also refer to a provider's processes and systems that track the quality of care provided to their patients.

- *Financial Viability.* Tufts Health Plan considers a provider's financial solvency in all reimbursement discussions and particularly for risk contracts, it is important to assess a provider's ability to withstand a deficit.

- *Risk Adjustment.* Tufts Health Plan's value-based contracts typically include a number of protections designed to hold providers harmless for insurance risk including severity adjustment for budget targets to reflect the underlying health of the provider's patient population, exclusion of several categories of spending that are inherently volatile (e.g., out-of-area expenses) from provider budget targets several categories of spending that are inherently volatile, and inclusion of PMPM caps on potential provider deficits which serves to protect against catastrophic consequences stemming from medical cost changes that may or may not be within their control. The dollar value of these caps, and the share of risk assumed by providers in value-based contracts, is calibrated during the negotiation process to reflect the provider's ability to manage medical costs and quality under these arrangements.

7. **Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited**

network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

Summary: Below are Tufts Health Plan's explanations for the average difference in prices for different products.

Response:
(1) Tiered network products - Tufts Health Plan's Your Choice family of tiered product options was launched during 3Q 2011 and represents Tufts Health Plan's primary tiered product offering. Pricing for the Your Choice products was developed in conjunction with Milliman to reflect:

- the expected value of member cost sharing changes
- anticipated utilization differences related to the differences in individual cost sharing component benefits among tiers, based on the 2010 Milliman Health Cost Guidelines
- the lower aggregate utilization expected from the less rich deductible plan designs
- unit cost differences among providers in each tier
- expected shifts in utilization away from tiers with less rich benefits

In 2012, pricing for the most popular Your Choice Large Group plan (HMO 3-Tier Option 3) was evaluated against a non-tiered plan with comparable member cost sharing to Tier 1 of the Your Choice plan. The premium for the Your Choice HMO 3-Tier Option 3 plan was 14.4% lower than the premium for the comparable large group plan with no tiering. Results would be similar for 2013.

(2) Limited network products - Tufts Health Plan first introduced our Select Network products in July 2007 with an underlying limited provider network that included a subset of Tufts Health Plan's contracted providers, several at reduced contracted rates. Over time, the number of providers in the Select network began to gradually increase, culminating in January 2013 with a sizable network expansion that more closely aligns the composition of the limited network with Tiers 1 and 2 of Tufts Health Plan's Your Choice tiered network product. In addition, the reduced rates initially accepted by many of the Select Network providers also began to erode. Currently, premium savings for the new expanded Select network plan designs are mainly derived from two features:

1) The concentration of care among lower cost providers compared to Tufts Health Plan's full network products, as reflected in an analysis based on the price relativity data submitted in June 2012 to the Division of Healthcare Finance and Policy, and updated for 2013 contracted rates and
2) Favorable utilization expected from the limited network plan design, as supported by analysis of our current limited network products.

Based on these features, savings for the expanded Select network products were evaluated at 11.1% beginning in January 2013.

The historical pricing differentials between our limited and full network products from 2009 – 2013 are shown in the table below. Note that these differentials are based on rates as of the end of each year. The primary driver for the decreasing differential is the addition of providers into the limited network and the associated impact on average unit cost.

Year	Pricing Differential: Limited vs. Full Network
2009	-13.5%
2010	-16.7%
2011	-16.7%
2012	-15.4%
2013	-11.1%

Supporting documentation:

1. *Attachment 1*: 1Q 2013 Small Group Rate Filing Attachment 9: Benefit Factor Development for Expanded Select Network
2. *Attachment 2*: 3Q 2011 Small Group Rate Filing Attachment 9: Benefit Factor Development for Your Choice HMO Product

8. **Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.**

Summary: Tufts Health Plan believes keeping employees healthy helps reduce overall medical costs and can create more productive and motivated employees. Tufts Health Plan has a wide range of programs to help employees and their dependents get healthy and stay healthy.

Response:

Wellness Programs offered to Employers

Worksite Wellness Programs

Destination Wellness

We offer a variety of worksite wellness programs. These programs are open to all companies that offer Tufts Health Plan, and all employees are eligible to participate, even if they're not Tufts Health Plan members.

To get started, our wellness professionals help form a wellness committee, assess the needs of its employees, assist with a Personal Health Assessment (PHA) campaign, and provide guidance on making the workplace a "culture of wellness." We offer seminars on a variety of topics including physical activity, nutrition, weight management and stress reduction. These programs are available for an additional fee. Biometric screenings to support a PHA campaign are available at no additional fee.

An employer group can download informative materials to educate and motivate their employees via the Web, e-mail, newsletters, and handouts. Resources are available on our Web site at: http://www.tuftshealthplan.com/destinationwellness/

Incentive Programs

We offer employer groups Active Focus—incentive programs designed to help promote and drive healthier behavior.

The Benefits of Active Focus

- Motivate members to take an active role in improving their health status
- Reward members for engaging in health and wellness activities
- Increase program participation

Wellness activities in our Active Focus incentive option programs:

Activity	*Description*
Personal Health Assessment	This online questionnaire educates employees on health status, identifies modifiable risks, identifies population risk, and provides recommendations that help members take action.
Know Your Numbers	Members get their key health measures (e.g., biometric screening), including total cholesterol, HDL, glucose, and blood pressure.
Healthy Living Programs	These online self-directed six-week programs include: Weight Loss, Get In Shape, Healthier Diet, Healthy Kids, Healthy Aging, Stress Relief, easy Start, Diabetes Fighting, Cancer Fighting, Healthy Heart, Healthy Seniors, and Smoke Free.

Employer Worksite Activities	Tufts Health Plan employers offer a health/wellness activity at the worksite. Examples include: "Biggest Loser," nutrition seminars, organized walks, lunch and learns, blood drives, CPR/AED training, and health fairs.
Challenges	Month-long programs are open to all employees.
Health Coaching	Eligible members work with health coaches on topics such as: Weight management, physical activity, eating habits/nutrition, stress management. This is available to fully insured employer groups and self-insured groups who purchased disease management.

Online Health and Wellness Tools

The My Wellness Plan portal complements our worksite wellness offerings and serves as the central hub for lifestyle management program components, content, and tools. It includes an efficient one-stop location for all member activities, services, and resources. The portal is designed to empower individuals with information and tools to lead healthy, happier lives based on our knowledge of their interests, overall health condition, readiness to change, and many other personal attributes. Some of the features and tools available include the following:

- Personal health assessment
- Health news
- Healthy living information (includes fitness and nutrition content, tips and interactive tools)
- Drug database that consists of medications, supplements and herbals
- Automated points tracking system
- Online seminars
- Self-care information (symptom checker)
- Health encyclopedia
- Video and audio libraries
- Chronic care information (includes centers for common chronic conditions)
- Personal and family health information (including pregnancy and self-care)
- Personal health record (member must opt for this feature)
- Healthwise content including decision points
- Secure messaging (message center)

The lifestyle management programs found on the portal are designed to maximize the opportunities to change behavior by keeping individuals fully engaged and motivated to make

modifications. We offer a comprehensive suite of 14 online Healthy Living programs designed to help individuals make key lifestyle changes that reduce health risks. Each evidence-based intervention is tailored to the member, leading to an engaging experience that promotes lasting and measurable health improvements. Following are the programs available:

- Easy Start
- Weight Loss
- Healthier Diet
- Get In Shape
- Healthy Aging
- Healthy Heart
- Diabetes Fighting
- Cancer Fighting
- Custom Program
- Stress Relief
- Smoke Free
- Healthy Kids
- Healthy Seniors
- Your Healthy Living Program (Maintenance)

Cost Benefit of Wellness Programs

Tufts Health Plan has made a significant investment in prevention and wellness. We believe that programs and initiatives designed to address health risk factors result in healthier and more productive members and, in the long term, have a favorable impact on our medical costs and customers' bottom lines. Tufts Health Plan is working with industry experts to develop a methodology for measuring return of investment (ROI) for wellness programs. ROI will vary across sub-populations due to differences in characteristics, disease prevalence, risk factor prevalence and previous care management status. Therefore, it is not feasible to predict the savings for any wellness program.

Discounts

We also offer the following health and wellness member discounts and benefits:

Fitness reimbursement

- Under a fully insured arrangement, Tufts Health Plan members who enroll in a qualified health club or fitness facility can receive up to $150 per calendar year toward membership fees. A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs and community fitness centers, as well as participating Tufts Health Plan fitness centers, Fitness Together and certain Curves locations.

- Under a self-insured arrangement, if an employer group elects to offer a fitness reimbursement benefit, Tufts Health Plan members who enroll in a qualified health club or fitness facility can receive up to $150 per calendar year toward membership fees. A qualified health club or fitness facility provides cardiovascular and strength training

exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs and community fitness centers, as well as participating Tufts Health Plan fitness centers, Fitness Together and certain Curves locations.

Fitness discounts

- Members receive a 20% discount on an annual membership at any participating fitness center with no initiation or joining fee (some centers require a $15 evaluation fee). Each dependent enrolled in Tufts Health Plan may choose his or her own center. Members may also visit our participating fitness centers and pay a small copayment at each visit for up to five visits per month. Fees vary between $0 and $6, depending on the member's age.

- Members can receive a 50% discount on any joining or initiation fee at participating Curves® facilities (listings are available at tuftshealthplan.com). Participating Curves facilities offer members a free one-month membership upon completion of 12 consecutive monthly membership payments.

- Tufts Health Plan members receive a 10% discount on the purchase price of personal training packages and a free initial fitness evaluation at participating Fitness Together facilities. Prior to beginning training at Fitness Together, a member receives a comprehensive fitness evaluation and work with his or her trainer to establish specific goals. The evaluation measures weight, body fat, circumferences, blood pressure, upper and lower-body strength levels, cardio endurance levels, and flexibility. The trainer then designs a customized workout program to help the member achieve those goals. Existing Fitness Together members are eligible to receive a 10% discount on the purchase of personal training packages of 36 sessions or more.

Weight management discounts

- Jenny Craig: Tufts Health Plan members can choose one of these offers:
  - FREE 30-Day Program
  - 25% off a Premium Program

- Nutrisystem: Members receive the following discounts/benefits:
  - 12% discount on the current promotion price of a Core or Select program
  - Plans are available for many lifestyle types, including vegetarians and diabetics

Exhibit D: Questions from CHIA

1. **Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?**

For Massachusetts Medicare Pioneer Accountable Care Organizations and providers in the Patient Centered Medical Home Initiative, Tufts Health Plan evaluates their performance along with our other contracted providers. We do not have a specific evaluation distinct from our overall network-based review.

a. If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.

N/A

Subscribed and sworn to, this sixteenth of September, 2013.

James Roosevelt, Jr.

James Roosevelt, Jr.
President and Chief Executive Officer

Tufts Health Plan

Response related to Requirement in 211 CMR 66.09 (m)(4)

Benefit Factor Development for Your Choice HMO Product

Pricing for Tufts Health Plan's family of tiered products was developed in conjunction with Milliman.

Benefit factors were developed by Milliman to reflect the expected value of member cost sharing changes as well as anticipated utilization differences due to the various cost sharing provisions. Milliman used Tufts Health Plan's existing HMO book of business claims experience to estimate the distribution of utilization and cost by tier, as well as the impact of member cost sharing. A claim probability distribution from the HMO experience was also created to value deductible and out-of-pocket maximum benefit parameters. Adjustments to utilization due to the underlying cost sharing differences among tiers were based on the 2010 Milliman Health Cost Guidelines. HMO claims incurred between January 1 – December 31, 2009, paid through June 2010 and trended to 2011, formed the basis of analysis. Final factors reflected the expected actuarial benefit differences relative to the baseline tiered plan (Your Choice HMO 3-Tier [Option 3]).

To ensure the relativity between the benefit level rate adjustment factors developed for the tiered plans and the actuarial value of benefits in other HMO products, Milliman modeled the net cost for Tufts Health Plan's HMO Value Plan and used that net cost to establish a baseline rating factor for the tiered plans relative to the Value Plan. The aggregate factor of .831 consisted of a .646 decrement for drug benefit differences and a .860 decrement for medical benefits.

Tufts Health Plan applied several additional adjustments to arrive at final benefit factors:

- While the Milliman factors incorporated the impact on utilization of the individual component benefits, an additional adjustment was made to the deductible plans to reflect the lower aggregate utilization expected from the less rich plan design. (-5%).
- No assumption was made in the Milliman factors for steerage to tiers with richer benefits. Although the impact was determined to be relatively small due to the offsetting effect of richer benefits on lower unit costs, a small adjustment was made to the factors for expected shifts in utilization away from tiers with less rich benefits (-1.8%).
- For plans offered with an HRA, half the value of these adjustments was applied.

Rate Development for Your Choice HMO 3-Tier [Option 3]:

	No HRA	With HRA
Relativity to Value Plan from Milliman	.831	.831
Relativity reweighted for Base Plan Medical/Rx mix	.829	.829
Utilization reduction	.950	.975
Steerage reduction	.982	.991
Adjusted Relativity to Value Plan	.773	.801
Final Relativity to Base Plan	.635	.658

The same process was followed for each of the Your Choice 3-tier and 2-tier HMO offerings. The final reductions to the base rate for each of the plans both with and without an HRA are presented in the table below. Descriptions of each of the plan designs themselves are provided at the end of the attachment.

Your Choice Plan	With No HRA	With HRA
Your Choice HMO 3-Tier [Option 2]	.677	.683
Your Choice HMO 3-Tier [Option 3]	.635	.658
Your Choice HMO 3-Tier [Option 6]	.610	.632
Your Choice HMO 3-Tier [Option 7]	.604	.626
Your Choice HMO 2-Tier [Option 2]	.636	.659
Your Choice HMO 2-Tier [Option 3]	.608	.630
Your Choice HMO 2-Tier [Option 5]	.608	.630
Your Choice HMO 2-Tier [Option 6]	.562	.582

Your Choice HMO 3-Tier Plan Designs

Plan Configuration	Your Choice HMO 3-Tier [Option 2]			Your Choice HMO 3-Tier [Option 3]		
	Copay	**Copay**	**Copay**	**Copay**	**Deductible then Copay**	**Deductible then Copay**
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Deductible, Coins, OOP Max						
Deductible* (ind/family)	N/A	N/A	N/A	N/A	$500/ $1,000	$2,000/ $4,000
Coinsurance*	N/A	N/A	N/A	N/A	N/A	N/A
Out-of-Pocket Max (ind/family)	$5,000/$10,000			$5,000/$10,000		
Pharmacy						
Retail copays	$15/$30/$50			$15/$30/$50		
PCP/Specialist Copays						
PCP office visits	$30	$40	$60	$15	$25	$45
Specialist office visits	$40	$50	$75	$25	$35	$50
Inpatient Hospital Care						
Inpatient Hospital Care	$500	$1,000	$1,500	$150	$500 deductible then $150 copay	$2000 deductible then $1000 copay
Outpatient/Day Surgery						
Ambulatory surgery center (free-standing)	$250	$250	$250	$150	$150	$150
Hospital surgical day care unit	$500	$1,000	$1,500	$150	$500 deductible then $150 copay	$2000 deductible then $1000 copay
High Tech Imaging(MRI, CT, PET & Nuclear Cardiology)						
Free-standing imaging center	$100	$100	$100	$50	$50	$50
Hospital (outpatient) or other provider	$100	$250	$450	$50	$500 deductible then $50 copay	$2000 deductible then $450 copay
Diagnostic testing, low-tech imaging/x-rays and diagnostic labs						
Any non-hospital provider	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Hospital (outpatient)	Covered in full	Covered in full	Covered in full	Covered in full	$500 deductible then covered in full	$2000 deductible then covered in full
Emergency Room Copay						
ER services (in ER)	$150	$150	$150	$100	$100	$100
Mental Health & Substance Abuse						
Outpatient MH & SA	$30	$30	$30	$15	$15	$15
Inpatient MH & SA	$500	$500	$500	$150	$150	$150

*Applies to the following hospital-based services: inpatient, day surgery, high-tech imaging and diagnostic tests/imaging/labs

Your Choice HMO 3-Tier Plan Designs (cont'd)

Plan Configuration	Your Choice HMO 3-Tier [Option 6]			Your Choice HMO 3-Tier [Option 7]		
	Copay	**Deductible then Covered in Full**	**Deductible then Copay**	**Deductible then Coins**	**Deductible then Coins**	**Deductible then Coins**
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Deductible, Coins, OOP Max						
Deductible* (ind/family)	N/A	$750/ $1,500	$2,000/ $4,000	$500/ $1,000	$1,000/ $2,000	$2,000/ $4,000
Coinsurance*	N/A	N/A	N/A	10%	20%	30%
Out-of-Pocket Max (ind/family)	$5,000/$10,000			$3,000/$6,000		
Pharmacy						
Retail copays	$15/$30/$50			$15/$30/$50		
PCP/Specialist Copays						
PCP office visits	$25	$35	$50	$25	$35	$50
Specialist office visits	$35	$50	$75	$35	$50	$75
Inpatient Hospital Care						
Inpatient Hospital Care	$350	$750 deductible then covered in full	$2000 deductible then $1000 copay	$500 deductible then 10% coins	$1000 deductible then 20% coins	$2000 deductible then 30% coins
Outpatient/Day Surgery						
Ambulatory surgery center (free-standing)	$350	$350	$350	$250	$250	$250
Hospital surgical day care unit	$350	$750 deductible then covered in full	$2000 deductible then $1000 copay	$500 deductible then 10% coins	$1000 deductible then 20% coins	$2000 deductible then 30% coins
High Tech Imaging(MRI, CT, PET & Nuclear Cardiology)						
Free-standing imaging Center	$150	$150	$150	$150	$150	$150
Hospital (outpatient) or other provider	$150	$750 deductible then covered in full	$2000 deductible then $450 copay	$500 deductible then 10% coins	$1000 deductible then 20% coins	$2000 deductible then 30% coins
Diagnostic testing, low-tech imaging/x-rays and diagnostic labs						
Any non-hospital provider	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Hospital (outpatient)	Covered in full	$750 deductible then covered in full	$2000 deductible then covered in full	$500 deductible then 10% coins	$1000 deductible then 20% coins	$2000 deductible then 30% coins
Emergency Room Copay						
ER services (in ER)	$150	$150	$150	$150	$150	$150
Mental Health & Substance Abuse						
Outpatient MH & SA	$25	$25	$25	$25	$25	$25
Inpatient MH & SA	$350	$350	$350	$500 deductible then 10% coins	$500 deductible then 10% coins	$500 deductible then 10% coins

*Applies to the following hospital-based services: inpatient, day surgery, high-tech imaging and diagnostic tests/imaging/labs

Your Choice HMO 2-Tier Plan Designs

Plan Configuration	Your Choice HMO 2-Tier [Option 2]		Your Choice HMO 2-Tier [Option 3]	
	Deductible (across tiers), then covered in full	**Deductible (across tiers), then copay**	**Deductible (across tiers), then covered in full**	**Deductible (across tiers), then copay**
	Tier 1	Tier 2	Tier 1	Tier 2
Deductible, Coins, OOP Max				
Deductible* (ind/family)	$500/$1000		$1000/$2000	
Coinsurance*	N/A	N/A	N/A	N/A
Out-of-Pocket Max (ind/family)	$5,000/$10,000		$5,000/$10,000	
Pharmacy				
Retail copays	$15/$30/$50		$15/$30/$50	
PCP/Specialist Copays				
PCP office visits	$20	$50	$25	$50
Specialist office visits	$35	$70	$40	$70
Inpatient Hospital Care				
Inpatient Hospital Care	$500 deductible then covered in full	$500 deductible then $1000 copay	$1000 deductible then covered in full	$1000 deductible then $1000 copay
Outpatient/Day Surgery				
Ambulatory surgery center (free-standing)	$250	$250	$250	$250
Hospital surgical day care unit	$500 deductible then covered in full	$500 deductible then $1000 copay	$1000 deductible then covered in full	$1000 deductible then $1000 copay
High Tech Imaging(MRI, CT, PET & Nuclear Cardiology)				
Free-standing imaging Center	$150	$150	$150	$150
Hospital (outpatient) or other provider	$500 deductible then covered in full	$500 deductible then $450 copay	$1000 deductible then covered in full	$1000 deductible then $450 copay
Diagnostic testing, low-tech imaging/x-rays and diagnostic labs				
Any non-hospital provider	Covered in full	Covered in full	Covered in full	Covered in full
Hospital (outpatient)	$500 deductible, then covered in full	$500 deductible, then covered in full	$1000 deductible, then covered in full	$1000 deductible, then covered in full
Emergency Room Copay				
ER services (in ER)	$150	$150	$150	$150
Mental Health & Substance Abuse				
Outpatient MH & SA	$20	$20	$25	$25
Inpatient MH & SA	$500 deductible then covered in full	$500 deductible then covered in full	$1000 deductible then covered in full	$1000 deductible then covered in full

*Applies to the following hospital-based services: inpatient, day surgery, high-tech imaging and diagnostic tests/imaging/labs

Your Choice HMO 2-Tier Plan Designs (cont'd)

Plan Configuration	Your Choice HMO 2-Tier [Option 5]		Your Choice HMO 2-Tier [Option 6]	
	Copay	Deductible then Copay	Deductible (across tiers), then Coins	Deductible (across tiers), then Coins (coins different than Tiers 1 & 2)
	Tier 1	Tier 2	Tier 1	Tier 2
Deductible, Coins, OOP Max				
Deductible* (ind/family)	N/A	$2,000/ $4,000	$2,000/ $4,000	
Coinsurance*	N/A	N/A	20%	30%
Out-of-Pocket Max (ind/family)	$5,000/$10,000		$5,000/$10,000	
Pharmacy				
Retail copays	$15/$30/$50		$15/$30/$50	
PCP/Specialist Copays				
PCP office visits	$25	$50	$25	$50
Specialist office visits	$35	$75	$35	$75
Inpatient Hospital Care				
Inpatient Hospital Care	$500	$2000 deductible then $1000 copay	$2000 deductible then 20% coins	$2000 deductible then 30% coins
Outpatient/Day Surgery				
Ambulatory surgery center (free-standing)	$250	$250	$250	$250
Hospital surgical day care unit	$500	$2000 deductible then $1000 copay	$2000 deductible then 20% coins	$2000 deductible then 30% coins
High Tech Imaging(MRI, CT, PET & Nuclear Cardiology)				
Free-standing imaging Center	$150	$150	$150	$150
Hospital (outpatient) or other provider	$150	$2000 deductible then $450 copay	$2000 deductible then 20% coins	$2000 deductible then 30% coins
Diagnostic testing, low-tech imaging/x-rays and diagnostic labs				
Any non-hospital provider	Covered in full	Covered in full	Covered in full	Covered in full
Hospital (outpatient)	Covered in full	$2000 deductible then covered in full	$2000 deductible then 20% coins	$2000 deductible then 30% coins
Emergency Room Copay				
ER services (in ER)	$150	$150	$150	$150
Mental Health & Substance Abuse				
Outpatient MH & SA	$25	$25	$25	$25
Inpatient MH & SA	$500	$500	$2000 deductible then 20% coins	$2000 deductible then 20% coins

*Applies to the following hospital-based services: inpatient, day surgery, high-tech imaging and diagnostic tests/imaging/labs

Tufts Health Plan

Response related to Requirement in 211 CMR 66.09 (m)(4)

Benefit Factor Development for Expanded Select Network

Select network products were first introduced in July 2007 with an underlying limited provider network that included only a subset of Tufts Health Plan's contracted providers. In recent years, Tufts Health Plan began to gradually increase the number of providers in the Select network, but even with the current network configuration, the Select products have not attracted significant membership. To better meet members' needs, and align the network with Tufts Health Plan's Your Choice products, Tufts Health Plan has decided to expand the current Select network to add the providers from Tiers 1 and 2 of our Your Choice products (2013 tiers).

Six new benefit plan options will be offered with the expanded Select network. Premium savings for the new expanded Select network plan designs are mainly derived from two features:

1) The concentration of care among lower cost providers compared to Tufts Health Plan's full network products, as reflected in an analysis based on the price relativity data submitted in June 2012 to the Division of Healthcare Finance and Policy, and updated for 2013 contracted rates and
2) Favorable utilization expected from the limited network plan design, as supported by analysis of our current limited network products.

Based on these features, savings for the expanded Select network products were evaluated at 11.1%. To ensure the relativity between the benefit factors developed for the Select products and the actuarial value of benefits in other full network HMO products, the resulting 11.1% savings were applied to the plan factors of each of the 6 full network products to arrive at the Select Network plan factors.

Below are the plan factors for the Select network products and the corresponding full network products with comparable member cost sharing.

	Full Network Product	Select Network Product
HMO Basic 20	0.776	0.689
HMO Basic 25/600	0.741	0.659
Advantage HMO 500	0.682	0.606
Advantage HMO 1000	0.641	0.570
Advantage HMO 1500	0.618	0.549
Advantage HMO 2000	0.599	0.533

In addition, effective January 1, 2013, members in the current Select network plans will transition to the new expanded network. The broadening of the provider network and associated increase in unit cost relativity, will result in an increase of 5% to the plan factors for the existing Select network products.