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