Frequently Asked Questions

What is TAHP?

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related healthcare entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. The association was founded in 1987, and represents the healthcare industry's commitment to improving healthcare for Texans.

What is TAHP's purpose?

The Texas Association of Health Plans is the statewide voice for health insurance organizations in Texas. TAHP serves as a resource for the Texas legislature, the state leadership, and various state agencies on matters affecting access to quality healthcare.

How does TAHP accomplish its goals?

TAHP is dedicated to advocating for public and private healthcare issues that improve access, value and quality of care for many Texans. We bring together industry leadership to develop answers to the critical healthcare issues in Texas through continuous communication with its members, industry and community stakeholders, as well as with representatives of the Legislature and state agencies.

What is the purpose of health insurance?

The purpose of health insurance is to help pay for medical care. People cannot predict what their medical bills will be in the future. In some years, the consumer may have low medical expenses. In other years, medical bills can be very large. With health insurance, consumers and their families are protected financially in the event of an unexpected serious illness or injury.

Consumers with health insurance also are more likely to have a regular doctor and more likely to get preventative medical care. As a result, they are likely to be healthier, which means they can enjoy a better quality of life and avoid major medical costs that can occur by waiting until they become seriously ill to seek care.

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How many Texans are uninsured?

Texas has the highest rate of people without health insurance in the country. According to the Current Population Survey estimates released September 2013 by the U.S. Census Bureau, 24.6 percent of Texans – more than 6 million people – were not insured in 2012. Comparatively, the national average is 16.4 percent.

The uninsured population includes those who cannot afford private health insurance; those who work in small businesses that do not offer employer group insurance; those who simply choose not to purchase health insurance, even though they can afford it; those who are eligible-but not enrolled-in government sponsored programs such as Medicaid or the Children's Health Insurance Plan (CHIP); and immigrants.

Health Plan Basics

(source: Texas Department of Insurance Consumer Guide)

The term "health plan" refers to both a health insurance policy sold by an insurance company and to an evidence of coverage sold by a health maintenance organization (HMO). Both types of health plans are commonly called "comprehensive" or "major medical" coverage. They cover a defined set of health care services and help you pay for medically necessary care.

Health plans won't pay for noncovered services, so it's important that you understand exactly what your plan covers. Also make sure you understand the costs you will be responsible for paying yourself, such as a deductible, copays, and coinsurance. Carefully review the Summary of Benefits and Coverage that comes with your health plan.

Health Maintenance Organizations

HMOs reduce costs by using networks of doctors and hospitals to provide their members' care. An HMO will usually only pay if you use doctors and hospitals in its network. There are exceptions for medical emergencies and for medically necessary services that aren't available in the HMO's network.

You must choose a doctor from the HMO's network to oversee all of your health care. This doctor is called your primary care physician. You must get a referral from your primary care physician if you want to see a specialist. Some HMOs offer a point-of-service option that gives you more flexibility to choose your doctors. You will still be required to choose a primary care physician, but you may go to out-of-network doctors without a referral. However, if you use doctors and hospitals that aren't in your HMO's network, you'll have to pay more out-of-pocket for your health care. A point-of-service plan may exclude the option for out-of-network care for some medical conditions. Point-of-service coverage is usually offered as an add-on to the plan – called a rider – for an additional fee.

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Preferred Provider Benefit Plans

A preferred provider benefit plan (PPO) is a network health plan offered by an insurance company. Although you can usually go to any doctor you choose, your out-of-pocket costs will be lower if you use doctors in the PPO's network.

Doctors and hospitals in the network have agreed to charge a discounted price for services to the PPO's members. Out-of-network doctors and hospitals haven't agreed to the discounted prices and often charge more than what your PPO plan will pay for your care. You'll usually have to pay this extra amount yourself. In addition, you'll probably have to pay a separate deductible and higher copayments and coinsurance for any care you received outside of the network.

Exclusive Provider Benefit Plans

Exclusive provider benefit plans (EPO) plans are similar to PPOs. They negotiate agreements with doctors and hospitals to provide care to their members at a discounted rate. You must use doctors and hospitals in the EPO's network. The primary difference between EPOs and PPOs is that PPOs will typically pay some of the cost of your care if you go to doctors or hospitals outside of their networks. EPOs will not. There are exceptions for medical emergencies and for medically necessary services that are only available outside the EPO network.

Individual Health Plans

Insurance companies and HMOs sometimes sell coverage directly to individuals. These policies can cover the individual only or can include a spouse and dependents.

Health plans cannot deny you coverage because of your medical history or because you have a preexisting condition. Typically, you can only buy an individual health plan during an open-enrollment period. This means you might not be able to buy insurance year round and shouldn't wait to buy coverage until you need it.

When determining what to charge you, insurance companies may consider only your age, where you live, whether you use tobacco, and whether the coverage you're buying is for one person or a family. They may not charge you more because of your gender or health status.

Under state and federal laws, all health plans must offer a certain set of benefits, called state-mandated benefits and federal essential health benefits. Federal essential health benefits apply to plans with an effective date on or after January 1, 2014. If you were enrolled in a plan on October 1, 2013, health insurance companies may choose to renew a plan that doesn't have the essential health benefits.

(Individual Health Plans continued on page 4.)

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(Individual Health Plans continued from page 3.)

Individual plans are categorized as either bronze, silver, gold, or platinum. These categories refer to the plan's actuarial value, which means the percentage of covered health costs that the plan pays, on average. A bronze plan pays 60 percent of your health costs for services covered by the plan. You have to pay the remaining 40 percent through deductibles, copays, and coinsurance. However, federal law limits the amount you have to pay out-of-pocket to $6,350 for an individual or $12,700 for a family. These levels will be adjusted for inflation over time.

Group Health Plans

Most Texans with health care coverage have an employer-sponsored plan. Employers often offer group health plans as part of an employee benefits package. Employers and groups that offer health coverage aren't required to contribute toward plan premiums, but many do. Some insurance companies require employers to pay at least 50 percent of an employee's premiums.

State and federal laws for group plans differ depending on the size and nature of the group.

Small Employer Plans

Small-employer plans are provided by businesses with between two and 50 employees. Federal law doesn't require small employers – those with fewer than 50 full-time employees – to offer health plans to employees. A small employer may decide to offer coverage to only full-time employees (those who work 30 hours or more per week) or to both full-time and part-time employees. Employers may not discriminate when deciding who they want to consider eligible for coverage.

State law prohibits small-employer plan rates from increasing more than 15 percent per year due to members' health status. State law also prohibits carriers from refusing to sell a policy to a small employer solely because of the employees' health status. Federal law prohibits companies from basing premium rates on members' health status. Companies may only base rates on age, geography, and tobacco use.

Large Employer or Other Large Group Plans

Large-employer plans are offered by businesses with more than 50 employees. If a large employer offers only an HMO plan, the law requires the HMO to make a point-of-service option available.

Federal law exempts large-group plans from the essential health benefits and rating requirements that apply to individual and small-group plans. Like other comprehensive health plans, however, large-employer plans must provide free preventive services. They may not have lifetime or annual dollar limits on coverage, and they can't deny coverage because of preexisting conditions or health history.

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Large Business Requirement

Large businesses that don't offer a plan that pays at least 60 percent of the cost of covered services will have to pay a penalty if any of their employees get a subsidy through the health insurance marketplace.

Large businesses are those with 50 or more full-time and full-time equivalent employees. Every 120 hours worked by part-time and seasonal employees in a month counts as a full-time equivalent for the purpose of determining whether a business has more than 5 full-time employees.

The penalty for failing to offer appropriate coverage is $2,000 per year for each full-time employee beyond the first 30 full-time employees. For employers that offer coverage for part of a year, the penalty will be calculated on a monthly basis.

Employers who offer coverage may still have to pay a penalty if the coverage costs more than 9.5 percent of an employee's taxable income. The penalty will be the lesser of $3,000 per year for each full-time employee that gets a health insurance subsidy, or $2,000 per year per full-time employee beyond the first 30 employees.

Note: The IRS has delayed these penalties until 2015.

Beginning in 2015, businesses with more than 200 employees must automatically enroll employees in a health plan. Employees may opt out of the automatic enrollment, but they must have comprehensive health coverage to avoid a tax penalty. People who are eligible for affordable comprehensive coverage through an employer plan aren't eligible for subsidies in the health insurance marketplace.

Self-funded Plans

Self-funded plans are governed by the federal Employee Retirement Income Security Act (ERISA). They are often called self-insured plans or ERISA plans. Employers who self-fund their health plans pay the costs of their employee's health care themselves, rather than buying coverage from an insurance company or HMO. Coverages may vary by plan and employer. Employers who self-fund their health plans may require employees to contribute to the cost of the plan.

The U.S. Department of Labor regulates self-funded plans, so TDI has very limited authority over them. These plans have their own procedures for complaints and dispute resolution. It's important to read your benefits handbook carefully. Questions and unresolved complaints should be directed to the Labor Department's Employee Benefits Security Administration (EBSA). For more information, call **EBSA** at 1-866-444-EBSA (3272) or 972-850-4500.

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What are Health Savings Accounts (HSAs)?

These are accounts offered by the federal government that were created by the Medicare bill signed into law on December 8, 2003. They are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis.

What is Medicare?

It is a government program that provides health insurance coverage for people age 65 and older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). Program eligibility does not consider income.

What is Medicaid?

It is a federally funded, state-run program that provides health insurance coverage to individuals and families with limited incomes and resources.

What is the Affordable Care Act?

On March 23, 2010 President Obama signed into law the federal health reform legislation known as the Affordable Care Act. The purpose of the legislation is to assure that all Americans have access to affordable health insurance. For more information, see our guide to the Affordable Care Act.

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