Working for Quality and Affordable Health Care for Texans

COST CONTAINMENT

Health Benefit Exchange

Preferred Provider Organization

Chronic Disease

Rate Review

Medical Loss Ratio

Federal Health Care Reform

TDI Sunset Review

STAR+PLUS

Prevention

Managed Care

Medicaid

Disease Managment

Obesity

Individual Mandate

HEALTH INFORMATION TECHNOLOGY

Rental Networks

Exclusive Provider Organization

SMOKING BAN

A Reference Guide for the 82nd Texas Legislature

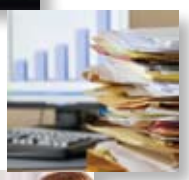
TAHP

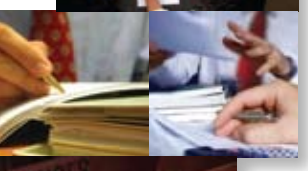
Texas Association of Health Plans

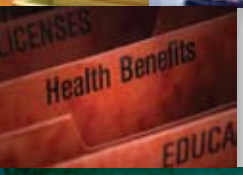
TABLE OF CONTENTS

To navigate to section, click on heading below.

ABOUT TAHP







The Texas Association of Health Plans (TAHP) was founded in 1987 as the voice of health plans operating in Texas. Its membership of health maintenance organizations, health insurers, and other health care-related entities include some of our state's top employers. TAHP members provide health coverage for more than 90 percent of insured Texans, underscoring the organization's commitment to improving access, value and quality of health care throughout the state.

TAHP brings together industry leadership to help forge solutions to critical health care issues facing Texas. Through their interaction with employers, consumers and providers, TAHP members bring unique insight and experience to the state's health care discussions. Serving as a resource to the Texas Legislature is a top priority of TAHP and its membership. It is in this role that TAHP offers its 2011 Legislative Guide.

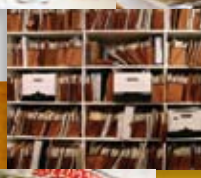
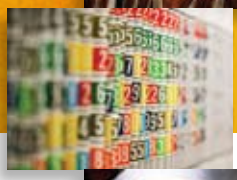
On behalf of its members, and the millions of Texans who benefit from health care coverage, TAHP is committed to enhancing our state's health care system by expanding access, maintaining affordability and ensuring quality care is delivered.

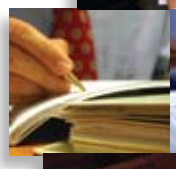
WHAT'S BEST FOR TEXAS

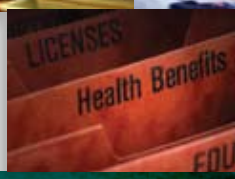










The choices made in the coming months will play a crucial role in determining the long-term viability of the Texas health care system. From state budget challenges to federal health care reform, the decisions made during the 82nd Texas Legislature will have a profound impact on Texans' access to high quality, affordable health care.

Regardless of how one feels about federal health care reform, and regardless of its ultimate fate both politically and legally, the fundamental challenges in our current health care system remain. Soaring medical costs, the toll of chronic diseases, a payment system based on volume of care rather than outcomes and a lagging use of health information technology within the state's medical infrastructure combine to present daunting challenges to our state health care system.

Below are brief summaries of these issues. The following pages offer suggestions that may be useful as state leaders work to devise a Texas solution to the health care challenges that face our state.

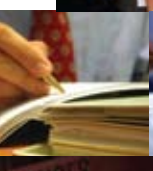
Slowing the Growth of Medical Cost

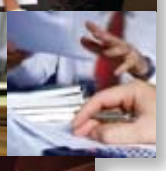
Of growing concern to Texans and most Americans is the mounting cost of medical care. A study released in 2010 by Milliman, Inc., which tracks the changes in average yearly health care costs, concluded that the average total medical spending for a "typical American family of four" covered by an employer-sponsored Preferred Provider Organization (PPO) plan reached $18,074 in 2010, an increase of $1,303 or 7.8 percent over last year. The total dollar increase is the highest in the history of the study. The study concluded that the primary reason for the increase in costs was the rising prices being charged by health care providers such as hospitals and doctors. Indeed, a 2007 report from the Agency for Health Care Research and Quality reinforces this phenomenon by indicating that hospital bills increased by almost 90 percent in the last decade. The combination of rising costs and increased utilization are threatening the sustainability of our health care system. This trend shows no sign of changing. Because these underlying costs are the primary driver of the premiums charged for health insurance coverage, rising medical costs remain the greatest single threat to the accessibility and affordability of health coverage in Texas.

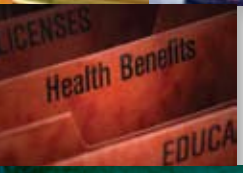
> **…rising medical costs remain the greatest single threat to the accessibility and affordability of health coverage in Texas.**

Managing Chronic Disease

Chronic health conditions continue to have a devastating human and financial toll on our society. A report by the Milken Institute released in 2007 found that the combined cost of treatment expenses and lost productivity for seven of the most common chronic diseases totaled $1.3 trillion in 2003. The research suggests that 80 percent of health care spending is used to treat just 20 percent of







the population, much of which is spent on treating chronic illness. The Milken report projected a 42 percent increase in the seven leading chronic conditions by 2023 costing $4.2 trillion in treatment costs and lost economic output. An effective strategy to combat chronic disease involves both prudent care management models for those already suffering from chronic conditions, as well as prevention strategies to minimize the incidence of chronic disease before it takes root.

A study released in 2008 by Health Grades projected that an average of 238,337 individuals die each year in the United States as a result of preventable medical errors.

Improving the Quality of Care

Exacerbating rising medical bills is the cost, both human and financial, associated with care involving medical errors and redundant or unnecessary medical treatments. Researchers from Dartmouth's highly respected Center for the Evaluative Clinical Sciences estimate that up to one third of the $2 trillion spent annually on health care today is unnecessary. They conclude that medical errors, duplicative procedures, overuse of high-end procedures, and unnecessary treatments and prescriptions all contribute to wasteful spending. The human cost is even more disconcerting. A study released in 2008 by Health Grades projected that an average of 238,337 individuals die each year in the United States as a result of preventable medical errors.

Focusing on Outcomes Rather Than Volume

The fee-for-service payment model currently prevalent in the Texas health care system is arguably a major force behind both rising medical costs and the waste associated with duplicative procedures and treatments. The fee-for-service model rewards medical care providers for quantity rather than quality, thus incentivizing wasteful and duplicative spending. Examples include the dramatic rise in medical spending paid for imaging services and outpatient surgeries in recent years, often as a result of doctor "self-referrals" to imaging and outpatient surgical clinics owned by the very doctors making the referrals.

The fee-for-service model rewards medical care providers for quantity rather than quality, thus incentivizing wasteful and duplicative spending.

Health Information Technology is Key to Health Care System Efficiency

Study after study reinforces that increased use of health information technology can save billions of dollars over the long term and dramatically improve administrative efficiencies and quality of our health care system. The U.S. Department of Health and Human Services estimates that widespread use of electronic medical records alone would save 100,000 lives and billions of dollars a year by reducing medical errors. The nonprofit RAND Corporation estimates that the widespread use of health information technology would reduce annual health care costs by $81

billion over a 15 year period. In addition to reducing medical errors and improving administrative efficiencies, health information technology can improve provider access to the most recent evidenced-based treatments available.

Health care providers who have made the transition agree. The Veterans' Administration, which has one of the most advanced computerized medical records systems in the country, boasts a prescription accuracy rate of 99.997 percent and outranks private sector hospitals in patient satisfaction surveys even though they spend less money per patient. Results from a 2008 survey released in the New England Journal of Medicine showed 80 percent of doctors who use computerized patient records report an improved quality of clinical decisions, 85 percent claimed such records improved delivery of preventive care, and 86 percent claimed such records helped reduce medical errors.

The U.S. Department of Health and Human Services estimates that widespread use of electronic medical records would alone save 100,000 lives and billions of dollars a year by reducing medical errors.

A Texas Solution

Regardless of the uncertain developments occurring with respect to national health care policy, Texas faces its own unique challenge to fashion and cultivate a system of health care that is sustainable, affordable and provides the access to high quality medical services that Texans deserve and desire.

TAHP believes a critical component to the state's health care infrastructure is a stable and competitive health insurance market.

We believe transparency and accountability are key to strengthening health care delivery in the state.

And we believe increased focus and investment in wellness, prevention and healthy living strategies will foster greater individual responsibility while enhancing the quality of life for those who choose a healthier life path.

We offer the following observations not as a response to federal actions but rather as tools to assist you in making decisions about the future of health care in our state based on what's best for Texas.

We hope that the information offered in this guide will assist you in developing effective solutions to the challenges we face.

We welcome the opportunity to work with you and other stakeholders in building a health care system of access, affordability and quality.

SOLUTIONS FOR A STABLE & COMPETITIVE TEXAS HEALTH INSURANCE MARKET

Sunset Review of the Texas Department of Insurance

Focusing the TDI Sunset review on the agency's mission and performance can help ensure a coordinated and modernized department provides appropriate industry oversight while fostering a viable and competitive insurance market for Texas businesses and consumers.

Medicaid Managed Care

Extending the efficiencies and quality of the state's successful managed care programs to areas not currently served will provide approximately $600 million in budget savings and state revenue during the 2012-2013 biennium.

Medical Loss Ratios

By joining other states in requesting a transition period for new federal medical loss ratio rules, Texas can minimize potential disruption to its individual insurance market and provide a transitional phase for implementation of the new guidelines.

Rate Review

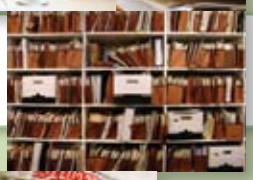
Rate review must be based on actuarial soundness, not artificial rate caps.

Rising Health Care Costs

Moving away from a fee-for-service payment model that rewards the volume of services provided rather than the quality of care delivered will help achieve the single most important thing needed to ensure the future viability of our nation's health care system – reducing skyrocketing medical costs.

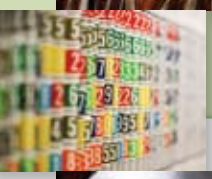
Individual Mandate for Coverage

Legislators should consider the negative impact of eliminating the individual mandate while retaining the insurance market reforms requiring guaranteed issue, a ban on pre-existing conditions, and modified community rating.



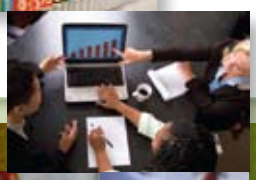
Texas Health Insurance Exchange

Texas should retain state control of its health insurance market by opting to establish and run its own Health Insurance Exchange rather than ceding control to the federal government.



Silent PPO

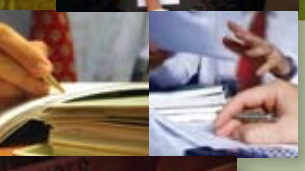
Legislators should oppose efforts to circumvent long-established federal laws exempting self-funded plans from state regulation.



Exclusive Provider Plans (EPOs)

The adoption of laws allowing for the operation of Exclusive Provider Plans (EPOs) in Texas will provide employers with the latest tool to control their health care costs and to continue offering quality care to their employees.

STRATEGIES FOR A HEALTHIER TEXAS



Obesity

The implementation of meaningful strategies to address the growing epidemic of obesity can save lives, reduce chronic illnesses, reduce health care costs, and save taxpayer dollars.

Secondhand Smoke

Adopting a statewide smoking ban will save lives, improve public health, reduce health care costs, and save taxpayer dollars.

SUNSET REVIEW OF THE TEXAS DEPARTMENT OF INSURANCE

This year's Sunset review of the Texas Department of Insurance (TDI) will again place the spotlight on the critical role TDI plays in determining the strength and viability of the state's health insurance market.

A coordinated and modernized Department can provide appropriate oversight of the health insurance industry while fostering the market's ability to provide Texas businesses and consumers quality health care choices at affordable prices. By focusing on the agency's mission and performance, the Sunset review process presents the opportunity to streamline TDI's regulatory process, modernize its operations and improve industry dynamics. Increased utilization of information technology can enhance report and data collection efforts, streamline form filings and reviews, and improve communications between consumers, health plans and providers. Additionally, changes to state law can eliminate outdated and unnecessary requirements on health plans which will reduce administrative costs.

While most of the issues included in the 2009 Sunset review of TDI remain the same, the adoption of federal health care reforms adds an array of new policy considerations regarding the state's role, and TDI specifically, in coordinating and regulating the Texas health insurance market.

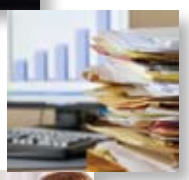
A coordinated and modernized Department can provide appropriate oversight of the health insurance industry while fostering the market's ability to provide Texas businesses and consumers quality health care choices at affordable prices.

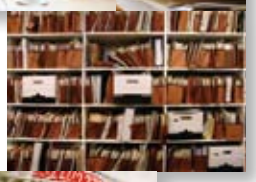
These new considerations come at a time of increasing uncertainty among consumers, insurers and employers about the future landscape of health insurance offerings in the state. For health plans, new and complex federal regulatory requirements present challenges that include restructuring of operations and products. Many of these new rules are certain to increase costs and ultimately impact premiums paid by purchasers. When combined with existing state regulations, new federal rules will not only take time to fully analyze and implement, but will also have the potential of creating significant market confusion if dual regulatory schemes proliferate within a state's insurance market.

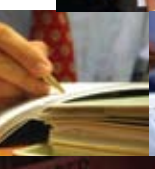
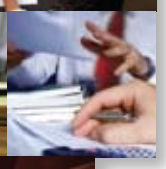
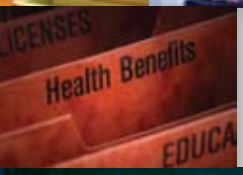
A brief review of the almost two-thousand page Texas Insurance Code reveals the highly regulated nature of the industry. In addition to licensure rules, state regulations include reporting requirements for proof of solvency, policy form approval, benefits offered, claim payments, deceptive trade practices, marketing, and relationships with physicians and other health care providers. Add to the state's extensive oversight rules the federal requirements of ERISA, COBRA and HIPAA, and the degree of industry regulation is unprecedented.

SUNSET REVIEW OF THE TEXAS DEPARTMENT OF INSURANCE







STATE REPORTING REQUIREMENTS FOR HEALTH INSURANCE COMPANIES

- Annual financial statement
- Balance sheet
- Receipts and disbursements for the preceding calendar year
- Number of individuals enrolled during preceding calendar year
- Number of enrollees as of the end of preceding calendar year
- Number of enrollments terminated during preceding calendar year
- An evaluation of quality of care
- Coverage areas
- Accreditation status
- Premium costs
- Plan costs
- Premium increases
- Range of benefits provided
- Copayments and deductibles
- Accuracy and speed of claims payment by the organization
- Credentials of the physicians of the organization
- Number of providers
- Updated financial projections for the next calendar year
- Total member months
- Total enrollment by group coverage
- Total enrollment by individual coverage
- Total encounters by physician
- Total encounters by non-physician
- Total patient days
- Total premiums for current year
- Total commercial premiums for current year
- Total premiums for two previous years
- Total revenue
- Total payments for physician services
- Total payments for medical and hospital benefits
- Total administrative expenses
- Ratio of medical and hospital benefits to total premiums
- Ratio of medical and hospital benefits to total expenses
- Ratio of administrative expenses to total expenses
- Total income

While little has been said about the critical task of aligning state regulations with new federal health insurance rules, the importance of doing so will be a crucial factor for determining the stability and competitiveness of the state's future health insurance market. The state will be well served to consider the effect of federal health care reform when evaluating any proposal to grant new authority to TDI.

For example, ensuring consistent regulations both inside and outside a state's Health Insurance Exchange will minimize the potential for adverse selection and the resulting higher premiums for certain segments of purchasers. Consistent rules will also help minimize product confusion among consumers and reduce health plan administrative costs, thus limiting their impact on the cost of coverage.

The new federal health care reform law also imposes many new reporting requirements on health plans. Many of these reporting requirements are similar to those currently in place at TDI or will include information already reported to TDI. Texas has an opportunity to streamline this process and enhance regulatory efficiency by reducing duplicative reporting requirements.

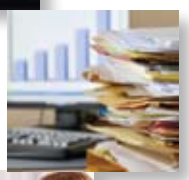
Insurers place a high priority on working with state policymakers and regulators to ensure that reasonable regulations are in place to protect consumers while also fostering a vibrant and stable insurance market. Striking that balance isn't always easy, but doing so is essential. Overregulation can destabilize a market, reduce the number of companies willing to compete, and limit choices while raising costs for consumers.

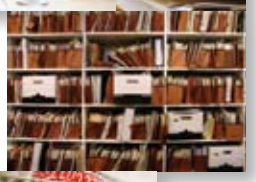
In 2011 state leaders will be presented a challenging but potentially beneficial opportunity to ensure the state's regulatory functions are modernized, fair, and consistent with new federal rules. Meeting this challenge can help ensure that Texans are provided access to affordable and high quality health coverage for themselves and their families.

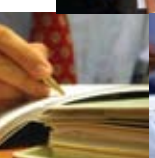
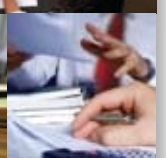
Focusing the TDI Sunset review on the agency's mission and performance can help ensure a coordinated and modernized department provides appropriate industry oversight while fostering a viable and competitive insurance market for Texas businesses and consumers.

MEDICAID MANAGED CARE PRODUCES BUDGET SAVINGS & QUALITY CARE








Texas: A leader in the use of Medicaid Managed Care

Texas is a national leader when it comes to controlling Medicaid costs and improving services through innovative managed care programs. Its STAR and STAR+PLUS programs have expanded care options for Medicaid clients while saving millions of dollars for taxpayers.

The state's current budget shortfall underscores the urgency of using these proven programs to maximize efficiency in its Medicaid program without sacrificing the quality of care provided. In response, the Texas Health and Human Services Commission projects the state can generate approximately $600 million in savings and increased state revenue for the 2012-2013 biennium by extending Medicaid managed care to areas of the state currently using less efficient models.

> **…the Texas Health and Human Services Commission projects the state can generate approximately $600 million in savings and increased state revenue for the 2012-2013 biennium by extending Medicaid managed care to areas of the state currently using less efficient models.**

Medicaid: Past to Present

Medicaid was created in 1965 under the federal Social Security Act and serves very low-income Texans: children and blind, aged, disabled or pregnant adults. The program, funded 60 percent by the federal government and 40 percent by the state, currently serves 1 in every 8 Texans.[1]

Under federal health reforms passed in 2010, the federal government will pay 100 percent for newly eligible beneficiaries for the first three years they are enrolled. Beginning in 2017 that will change with the federal government paying:

■ 95 percent in 2017 ■ 94 percent in 2018 ■ 93 percent in 2019 ■ 90 percent in 2020 and beyond

Since Medicaid was designed as a federal entitlement program, the state may not limit enrollment for qualified Texans.

In the early 1990s, Texas lawmakers addressed growth in the program by creating the State of Texas Access Reform (STAR), an HMO model managed care program providing acute care services for low-income Texas children and families as well as certain adults with disabilities. Lawmakers created STAR+PLUS in 1998 to integrate those acute care programs with long-term care programs for the elderly and other disabled adults. STAR+PLUS is now a nationally recognized model for Medicaid managed care with its expanded care options and reduced costs. STAR+PLUS, with high satisfaction rates among enrollees, now serves about 170,000 Medicaid enrollees in 29 Texas counties.[2]

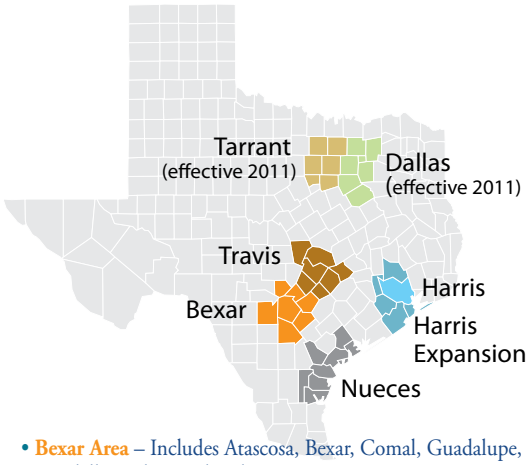
Cost Controls Are Key

To contain costs within the Medicaid program and to help address the state's budget shortfall, state leaders recognize the necessity of identifying viable alternatives to traditional Medicaid approaches such as the fee-for-service or the Primary Care Case Management (PCCM) models. Neither are designed to contain costs or offer the budget certainty of an HMO model.

By contrast, the Medicaid Managed Care (MMC) model offers cost controls that promote efficiencies, improve quality and minimize the state's financial exposure. MMC models, such as STAR and STAR+PLUS:

- Eliminate the traditional fee-for-service model in which the state is responsible for payment of all bills;
- Let the state pay a fixed fee per-person per-month, known as capitation;
- Provide budget certainty – capitation limits the state's financial exposure;
- Require managed care organizations to pay for all medically necessary care;
- Guarantee access to services for enrollees; and
- Create budget savings for the state.

STAR+PLUS Statewide Service Areas



- **Bexar Area** – Includes Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson counties
- **Dallas Area** (starts 2011) – Includes Collin, Dallas, Ellis, Hurt, Kaufman, Navarro and Rockwall counties
- **Harris Area** – Harris County
- **Harris Expansion** – Includes Brazoria, Fort Bend, Galveston, Montgomery and Waller counties
- **Nueces Area** – Includes Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria counties
- **Tarrant Area** (starts 2011) – Includes Denton, Hood, Johnson, Parker, Tarrant and Wise counties
- **Travis Area** – Includes Bastrop, Burnet, Caldwell, Hays, Lee, Travis and Williamson counties

HHSC Health Plan Operations 2009

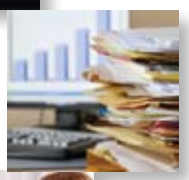
How Medicaid Managed Care Works

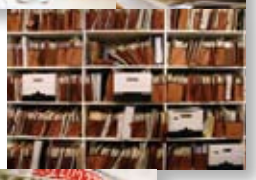
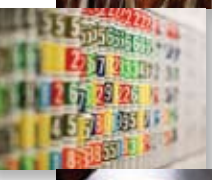
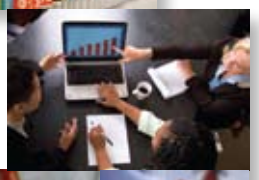
The state pays a fixed rate to participating managed care health plans in return for providing comprehensive medical benefits to qualified Medicaid enrollees. The capitated rate is paid on a per-person, per-month basis and can vary, depending on the eligibility – children, pregnant women, the elderly or disabled. In return for the fee, the health plans manage all medical services and administrative functions of the program and assume responsibility for all payments associated with the medical care of an enrollee even if the total exceeds the capitated amount.

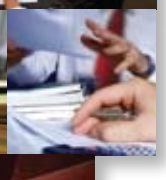
This system guarantees budget certainty to the state, but it does not mean enrollees receive less care. Under STAR and STAR+PLUS, health plans use innovative care coordination and focus on preventing hospitalizations, often resulting in more health care options for enrollees.

MEDICAID MANAGED CARE PRODUCES BUDGET SAVINGS & QUALITY CARE








With a focus on prevention, health plans detect and treat health problems before they become more complicated and expensive. Efficient management of resources is also achieved through promotion of healthy lifestyles and care coordination to eliminate duplication of services.

Medicaid managed care plans reduce costs and improve care with a host of tools and strategies.

Medical homes – Enrollees chose a primary care physician to provide them with a medical home to reduce the use of expensive emergency rooms for routine services such as well checks.

Innovative care delivery – Service coordinators help enrollees live independently in their own homes by working with individuals and their families to ensure long-term support and community care options are in place.

Disease management – Costs are reduced and quality of life is enhanced through care plans to manage chronic conditions such as asthma and diabetes. Strategies can also focus on childhood obesity to stave off or control high medial costs associated with early onset diabetes.

Prevention strategies – Medicaid managed care plans can provide services traditional Medicaid does not cover if they know it will lead to better health outcomes and significant savings. For example, noting that a premature birth costs $1 million more than a full-term birth, one plan paid for 17P progesterone injections for women with high-risk pregnancies.

Flexible incentives for physicians – By providing incentives for physicians to offer after-hour care, managed care plans can reduce the use of high-cost emergency rooms for non-emergencies.

Accountability Guards Tax Dollars

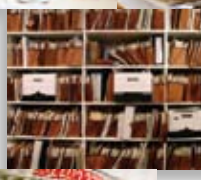
Taxpayer dollars are protected in the managed care model, too, with these safeguards:

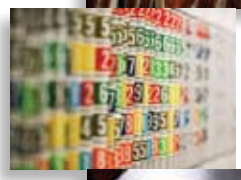
- Value-based contracts that ensure enrollees receive the care they need;
- Performance standards, quality measurements and program reporting requirements;
- Three types of audits – for claims, financial reporting and operations;
- Contract regulations and oversight;
- Corrective action plans, fines, sanctions, and liquidated damages for providers who fail to comply;
- Caps on administrative costs; and
- Caps on profits.

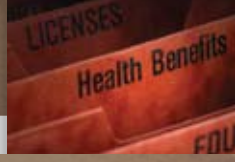
Extending Managed Care = $600 million in Budget Savings

All Texas counties offer traditional Medicaid, but only enrollees living in mostly urban areas of the state are given the option of enrolling in STAR+PLUS.

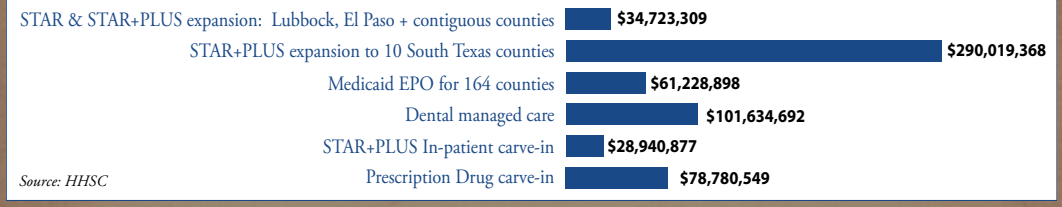
While more than 2 million Texans are enrolled in a Medicaid managed care plan, more than 800,000 Medicaid recipients are unable to benefit from the efficiencies and improved health outcomes of managed care.[3] Yet HHSC now estimates that the state can generate savings and state revenue of approximately $600 million during the 2012-2013 biennium by expanding the use of Medicaid managed care.







Proposed Savings for Medicaid Program 2012/2013



Source: HHSC

Roughly half of those savings – nearly $300 million – can be realized if managed care is offered in 10 South Texas counties where 350,000 Medicaid recipients are not currently benefiting from managed care.

Adequate funding for the program will be essential to provide the state's managed care organizations (MCOs) the ability to develop actuarially sound rates to operate the program and generate the projected savings. Additionally, program carve outs and restrictions on the MCOs' ability to contract with providers could reduce their effectiveness and flexibility in managing care.

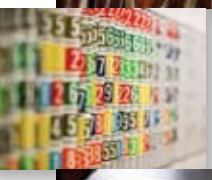
Texas' investment in STAR and STAR+PLUS managed care programs have resulted in national recognition for proven results that reduce costs and provide budget certainty and accountability safeguards for taxpayers.

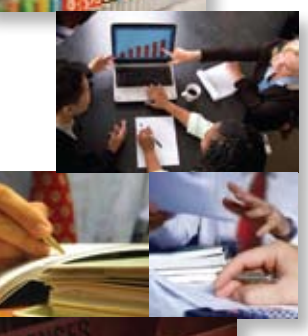
No Time for Experiments

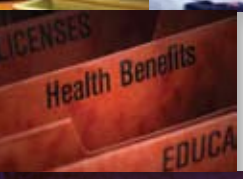
Texas' investment in STAR and STAR+PLUS managed care programs have resulted in national recognition for proven results that reduce costs and provide budget certainty and accountability safeguards for taxpayers. Some groups have resisted any changes to the fee-for-service or PCCM models and continue to offer alternative and untested models that they design and control. In the past, such experiments have failed and wasted tax dollars. These past failures reinforce the value of the state's investment in developing its STAR+PLUS model with its proven results.

Extending the efficiencies and quality of the state's successful managed care programs to areas not currently served will provide approximately $600 million in budget savings and state revenue during the 2012-2013 biennium.

MEDICAL LOSS RATIOS - PROVIDING A TRANSITION TO ENSURE A STABLE MARKET







> **With health plan administrative costs totaling only four percent of total health care spending, it is clear that non-clinical spending by health plans is not a significant health care cost driver.**

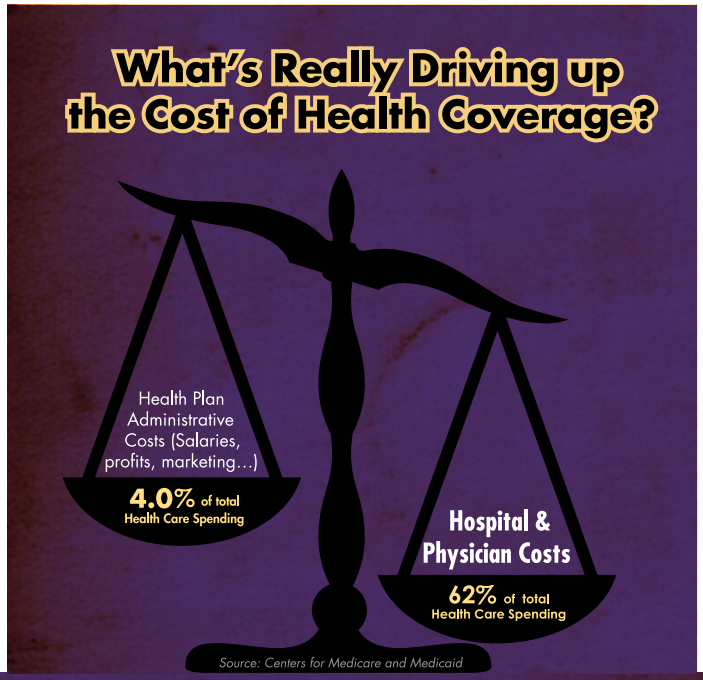
The Patient Protection and Affordable Care Act (PPACA) places strict new limits on how health plans pay for the medical and administrative programs they provide.

These new restrictions place limits on a health plan's medical loss ratio (MLR) – an accounting term that refers to the percentage of premium dollars a health plan spends on direct medical care. The new government rules dictate that beginning in 2011, 80 percent of health premiums in the individual and small employer (group) markets and 85 percent in the large employer (group) market must be spent on medically related services. If a plan is unable to meet these new spending thresholds, it will be required to provide rebates to its customers equal to the amount it exceeds the MLR limits. Forcing such rebates could result in a health plan operating at a loss for the year, producing insolvency issues for the company and loss of coverage for consumers.

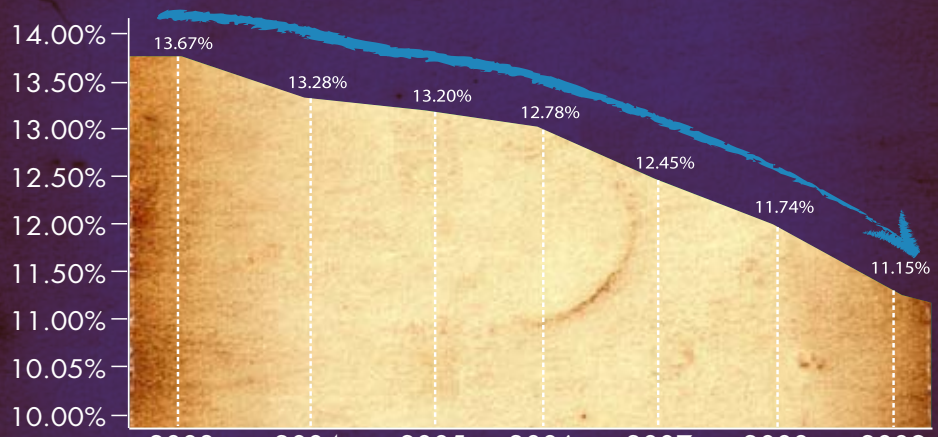
The new law is so restrictive that it prevents a health plan from combining its overall experience to determine its medical loss ratio. As a result, a health plan could be required a to provide rebates in one state that may be slightly under the required MLR level even if it is well above the requirements in all other states.

Advocates for government control over how health plans fund their operations have implied that restrictive MLR regulations will help reduce medical costs and lower premiums. With health plan administrative costs totaling only four percent of total health care spending, it is clear that non-clinical spending by health plans is not a significant health care cost driver.[4] Moreover, health plan administrative costs have been declining for years. In 2009, the percentage of premiums that went to health plan administrative costs and profit declined for the sixth year in a row.[5]

Proponents of MLR regulation also assert that the delivery of quality medical care can only be achieved through direct medical spending. To embrace this conclusion would ignore the significant investment health plans continue to make in non-clinical programs that yield significant results in improving health outcomes, reducing medical



FACT: In 2009, the percentage of premiums that went toward administrative costs and profits declined for the sixth year in a row.



Source: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2009.pdf
http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

errors, reducing complications, enhancing patients' quality of life, and reducing the long-term growth rate of health care costs.

The MLR requirements also imply that all medical services are needed and effective and that higher levels of clinical spending are synonymous with better health. Such an assumption has been shown not to be the case and ignores the fact that unnecessary medical interventions can have serious negative consequences on patients.

Non-clinical programs such as chronic disease management, care coordination, quality reporting, wellness and health promotion activities, nurse hotlines, health information technology, and pay-for-performance continue to be recognized by independent health care experts for the significant contributions they make to improve health care quality.

While recent MLR regulations adopted by the federal government will allow certain activities aimed at improving quality to be considered as non-administrative spending in determining an MLR, compliance with the new MLR levels may force health plans to eliminate or significantly reduce their investments in many of these worthwhile initiatives. Doing so will clearly affect their ability to influence the cost and quality of health care consumers receive. The restrictions may also lead some insurers to reduce coverage options or exit the health insurance market altogether, creating fewer choices for consumers. This possibility is real; several companies operating in Texas have already announced they will no longer offer health insurance in the state.

Recognizing the potential adverse impact the MLR regulations could create for insurance markets and consumers, the PPACA provides the Secretary of Health and Human Services the authority to grant state waivers from the new restrictions to avoid disruption in individual health insurance markets.

Texas can guard against the potentially negative effects of the new regulations on its consumers by joining other states that are seeking a waiver from the government-imposed MLR rules. By doing so, Texas can allow insurers operating within the state a transition period to implement the new restrictions and limit any adverse effect the new standards may have on the state's insurance market.

By joining other states in requesting a waiver from new federal medical loss ratio rules, Texas can minimize potential disruption to its individual insurance market and provide a transitional phase for implementation of the new guidelines.

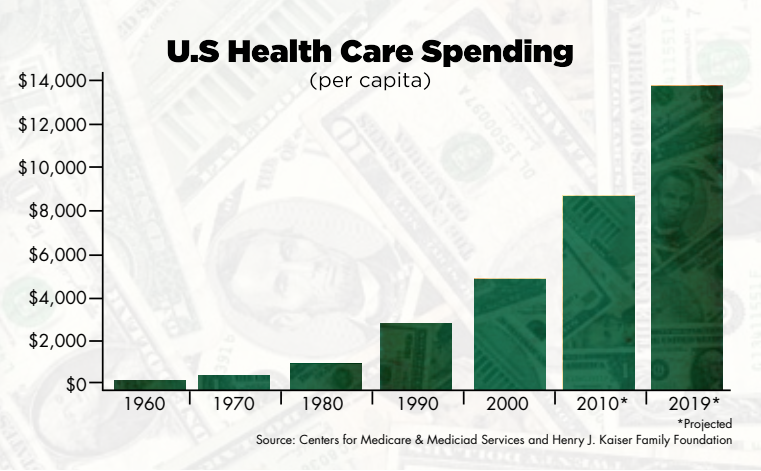
RATE REGULATION WILL NOT LEAD TO LOWER MEDICAL COSTS

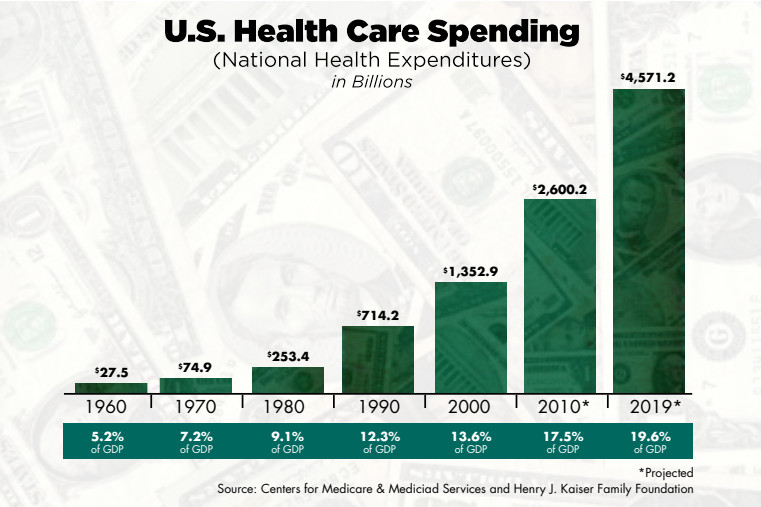
The 2010 federal health care debate has focused the nation's attention on the rising cost of health insurance coverage, leading some to argue that regulating insurance rates will somehow lower the cost of health care. This approach ignores the fundamental reality that the primary driver of health insurance premiums is skyrocketing medical costs. Health insurance is expensive because health care is expensive. According to a 2005 study conducted by the RAND Corporation, medical costs account for nearly 89 percent of every health care dollar. Unless measures are adopted to address rising medical costs, no amount of insurance rate regulation will make health care more affordable.

Unless measures are adopted to address rising medical costs, no amount of insurance rate regulation will make health care more affordable.

Leading Cost Drivers: Medical Costs

U.S. health care spending surpassed $2.3 trillion in 2008, more than three times the $714 billion spent in 1990 and over eight times the $253 billion spent in 1980. Government data from the Office of the Actuary in the Centers for Medicare and Medicaid Services (CMS) show that in 2009 rising costs for hospitals, physicians, and prescription drugs combined with a declining economy to result in the largest growth in health care spending as a share of GDP since the government started keeping track 50 years ago.





The rising cost of medical care pushes up the level of premiums needed by insurers to ensure that claims can be paid. If insurers fail to collect sufficient premiums, they face potential insolvency, putting policyholders at risk of having their claims unpaid and decreasing competition as health insurers exit the market.

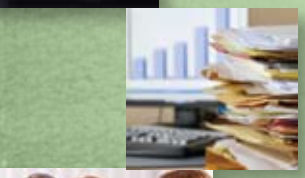
Arbitrarily capping premiums or otherwise unduly regulating premium rates without taking into consideration the underlying medical costs driving those premiums could undermine the very viability of the insurance industry as a whole and the coverage that families and employers count on today. Rate regulation must be conducted in a manner that ensures premiums will provide sufficient capital to cover the projected medical costs of policyholders and the costs associated with managing their health coverage.

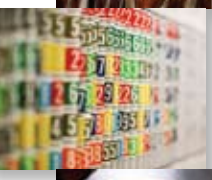
Regulation of Health Insurance in Texas

Texas has always played an extensive role in regulating premium rates for the individual and small group markets. The Texas Department of Insurance (TDI) currently has the authority to disapprove an individual policy form if the commissioner determines that "the benefits provided are unreasonable in relation to the premium charged."

RATE REGULATION WILL NOT LEAD TO LOWER MEDICAL COSTS









- **FOR INDIVIDUAL PLANS:** Actual rate schedules must be filed with TDI when an insurer files a new policy form.
- **FOR HMO PRODUCTS:** No schedule of charges may be used until a copy of such formula or method is filed with supporting documentation. Each formula for calculating the schedule of charges must be accompanied by the certification of a qualified actuary stating that, based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate, or unfairly discriminatory.
- **FOR SMALL GROUP HEALTH PLANS:** Rates must be reasonable, reflect objective differences in plan design, and may not vary beyond prescribed percentages from the rate for other businesses in the same class, or from one class to another. Insurers must file an annual actuarial certification that rates comply with accepted actuarial practices and must maintain documentation that rates comply with accepted actuarial assumptions.

New Federal Regulations

In addition to current Texas regulations, new federal legislation requires federal authorities to work jointly with TDI to review unreasonable increases in premiums for health plans. Plans that propose "unreasonable" rates will be required to provide a justification for the increase and post the justification on their website. TDI may question the methodology and actuarial assumptions used to support the proposed increase and request additional documentation.

Rate Review Should Focus on Actuarial Soundness, not Artificial Rate Caps

Texas law requires that health plan premiums be both fair to the consumer and sufficient to cover the medical costs of policyholders. If premiums lag behind projected medical costs, health insurance companies risk financial insolvency, thus endangering the policyholder.

In order to ensure solvency of the risk pool, a health plan's actuarial team reviews historical and current data to determine what expected medical costs will be incurred by policyholders in the near and long term. They evaluate known past experience of the use of medical services, demographic and trend projections, adverse selection, and predictions of future utilization and costs. As a result, actuaries can determine what premium rates will be sufficient to meet the medical needs of policyholders and to cover the administrative costs of managing the plan – enrollment, customer service, claims processing, care management and quality review, etc. Rate plans submitted to TDI include certification by a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce rates that are both fair to the policyholder and sufficient to cover projected medical costs.

Attempts to place artificial rate caps on premiums, or otherwise to hold rates below levels that are necessary to meet projected costs, will only destabilize the market and place the policyholder at risk.

Government rate review of health insurance premiums must take into account projected rising medical costs and ensure the actuarial soundness of health plans. Attempts to place artificial rate caps on premiums, or otherwise to hold rates below levels that are necessary to meet projected costs, will only destabilize the market and place the policyholder at risk. Capping premium increases without evaluating the underlying reasons for the rise is similar to capping the prices automakers can charge consumers, while allowing the steel, rubber, and technology manufacturers to charge the automakers whatever they want.

The market shares of health plans and competitiveness of the markets they operate in is itself a form of rate review. In Texas, the market's competitiveness combined with the state's existing oversight has provided a level of market discipline that has resulted in a wide array of choices, lower prices and motivation for insurers to be creative in developing insurance products that closely meet the demands of purchasers.

A 2008 survey conducted by the General Accounting Office on the number of carriers in the small employer market showed the Texas market to be one of the most competitive in the nation.

According to the survey results, Texas enjoys one of the least concentrated small employer markets in the country. The study found:

- The median number of licensed insurers in the small group market per state was 27. Texas has 46 small group carriers.
- Nationally, the median market share of the largest carrier in each state was 47 percent with a range of 21 percent in Arizona to 96 percent in Alabama. Texas' largest small group carrier has just 27 percent of the market.
- The five largest carriers in the small group market in each state represented 75 percent of the market in 34 of 39 states and 90 percent in 23 of those states. Texas' five largest small group carriers represented just 68 percent of the market.

Industry experts attribute the competitive nature of the Texas market to the lack of regulation for small employer rates.

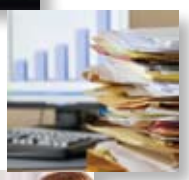
"You are not necessarily helping the consumer if you keep rates artificially low. What's worse for the consumer: having a premium increase or having to pay the full amount of a medical expense because the company is out of business."

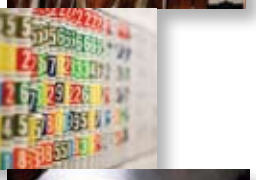
—Sandy Praeger, Kansas Insurance Commissioner, 07/09/10.

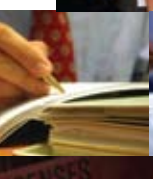
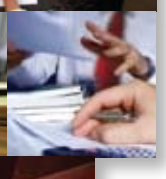
Rate review must be based on actuarial soundness, not artificial rate caps.

CONTAINING COSTS IS KEY STEP FOR NATION'S HEALTH CARE SYSTEM








There is little debate about the challenge skyrocketing medical costs pose to our nation's health care system. Because they are a primary driver of the premiums for health coverage, rising medical costs remain the greatest threat to the accessibility and affordability of health coverage in our country. Slowing the rapidly increasing cost of medical care remains the single most important thing that must be done to ensure the future viability of our nation's health care system.

While many feel the PPACA falls well short of including the sweeping strategies that are necessary to bend the health care cost curve downward, it does include a series of cost containment pilots aimed at laying the groundwork to slow the rapid rise in the cost of medical care. Central to those strategies are payment reforms that will move the nation's health care system away from a fee-for-service payment model that rewards the volume of services provided rather than the quality of care delivered.

Pilot programs to expand accountable care organizations, bundled payments, medical homes, and chronic disease management have been combined with Medicare and Medicaid reforms to reward doctors and hospitals for providing high-quality care rather than simply continuing to pay for a high volume of services. Small business grants for wellness programs, eliminating patient co-pays for preventive services, and grants for entities that promote public health are also among the strategies proposed to reverse the upward trend of medical costs.

Regardless of one's feeling about the federal reforms or their ultimate legal or congressional fate, the inclusion of these cost containment measures provides policymakers at the federal and state

Bundled Payments

The practice of bundling reimbursement for multiple providers (doctors, hospitals, and others) into a single comprehensive payment that covers all of the services provided in a patient's episode of care. Bundled payments are often referred to as case-rates or episode-based payments.

Accountable Care Organization

An organization or group of health care providers including hospitals, primary care doctors and specialists who can be held accountable for the quality and cost of care delivered to the patients it serves.

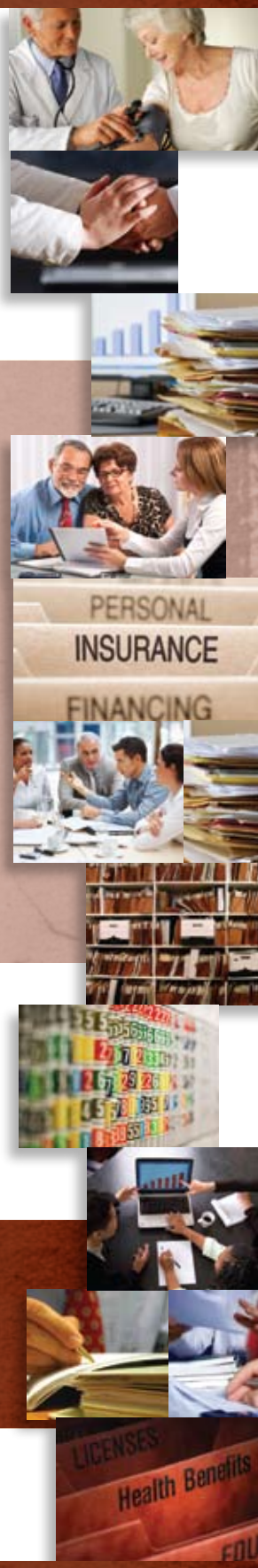
levels a blueprint for strategies that may be employed to achieve reduced cost growth while improving the quality of care.

Below are several strategies developed by health plans, provider organizations and other stakeholders to offer guidance for efforts to create a more stable and sustainable health care system. TAHP is committed to working in a public/private partnership with state leaders and other health care stakeholders to advance proposals consistent with these ideals, with the goal of reducing the rate of increase in future health and insurance costs. These strategies include:

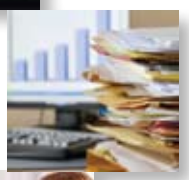
- Implementing proposals in all sectors of the health care system, **focusing on administrative simplification, standardization and transparency** that supports effective markets;
- Reducing overuse and underuse of health care by **aligning quality and efficiency incentives among providers** across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together toward the highest standards of quality and efficiency;
- **Encouraging coordinated care,** both in the public and private sectors, and **adherence to evidenced-based practices and therapies** that reduce hospitalizations, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies; and
- **Reducing the cost of doing business by addressing cost drivers** in each sector and through common sense improvements in care delivery models, health information technology, workforce deployment, and development and regulatory reforms.

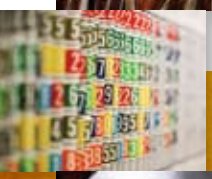
Securing a stable and sustainable health care system for the future will require extraordinary leadership and commitment from both the public and private sectors. TAHP is committed to doing its part in helping make Texas a national leader in reducing the rate of growth in health care costs.

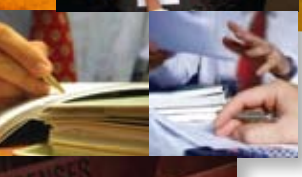
Moving away from a fee-for-service payment model that rewards the volume of services provided rather than the quality of care delivered will help achieve the single most important thing needed to ensure the future viability of our nation's health care system – reducing skyrocketing medical costs.



WHY AN INDIVIDUAL MANDATE?







Requiring that everyone be covered without regard to a pre-existing medical condition was one of the more popular aspects of the federal health care reforms. This component of the reforms provided access to health care to countless Americans who had previously been uninsurable due to an existing medical condition. It also provided others the comfort of knowing that they too would have access to care and be protected from financial devastation should an unfortunate and unexpected serious medical condition befall them.

The underlying challenge of providing guaranteed coverage lies in the fact that an individual who knows he can obtain health coverage whenever it is needed will often wait until it is needed to purchase it. The result is a process known as adverse selection, where an insurance risk pool is dominated by sicker individuals with higher than average medical costs. Such a scenario is akin to delaying the purchase of insurance for your car until after you've been involved in an accident and experienced vehicle damage.

When only sicker individuals seek coverage, the risk pool is smaller and premiums are higher due to higher medical costs for those in the pool.

When only sicker individuals seek coverage, the risk pool is smaller and premiums are higher due to higher medical costs for those in the pool. As premiums increase, the problem is compounded as healthier persons leave the pool by dropping coverage rather than pay higher premiums, causing the risk pool to shrink even further and premiums to rise even more. This adverse selection spiral can threaten the solvency and existence of the pool as premiums become unaffordable.

To address the danger of adverse selection, federal lawmakers included the "individual mandate" that requires all persons above a certain income level to purchase health insurance. The logic of this approach is to ensure that a large enough pool of persons exists to enable the cost of medical care for those in the pool to be spread widely, thus keeping premiums low for everyone.

…the five states that have tried individual market reforms without an individual mandate to purchase insurance are now among the most expensive states in which to buy non-group insurance.

The central role that an individual mandate plays in a system of guaranteed coverage is borne out by empirical research. A report by Milliman, Inc., found that states that enacted laws requiring health insurance companies to cover all applicants regardless of pre-existing conditions, without also requiring individuals to purchase coverage, incentivized people to defer seeking coverage until they had health problems - a situation that unfairly penal-

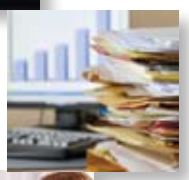
izes those who are currently insured. According to the report, those states that enacted such laws saw a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured. In fact, the five states that have tried individual market reforms without an individual mandate to purchase insurance are now among the most expensive states in which to buy non-group insurance. Additionally, the Congressional Budget Office estimated that the PPACA's expanded coverage requirements would cause premiums in the individual market to increase by 27 to 30 percent, with this increase mitigated by the presence of the individual mandate. A more recent report by MIT economist Jonathan Gruber estimates that the impact of eliminating the individual mandate without amending other elements of the federal law would result in premiums increasing by 27 percent.

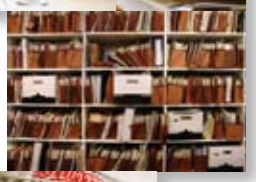
The above research reveals the crucial role that the individual mandate serves in a system of guaranteed coverage. Without it, the risk pool of insured persons will be small, those who are insured will pay higher premiums, and the ranks of the uninsured will burgeon as healthy persons defer participation in the system until they need it, thus exacerbating the very problems health care reform was designed to solve.

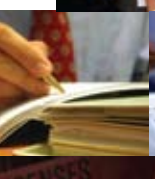
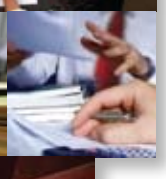
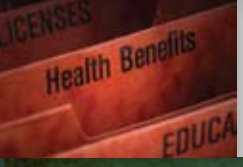
Legislators should consider the negative impact of eliminating the individual mandate while retaining the insurance market reforms requiring guaranteed issue, a ban on pre-existing conditions, and modified community rating.

STATE HEALTH INSURANCE EXCHANGES: ORGANIZED MARKETS FOR HEALTH COVERAGE







The introduction of Health Insurance Exchanges into the 2010 federal health care debate was not the first time the concept had been considered. The concept of "managed competition" that would exist within an Exchange was initially proposed in the 1970s, and over the years it has received bipartisan support at both the state and federal levels, including approval from such organizations as the Heritage Foundation. Support for Exchanges has been based on the concept that the larger risk pools create a more effective way to spread risk among those covered. Many industry observers believe insurance exchanges are a concept that states would have been wise to consider on their own without the impetus provided by federal health care reform. Some states had already adopted an Exchange market approach prior to the passage of the federal reforms, including conservative Utah and historically liberal Massachusetts.

With the goal of simplifying the purchasing process and providing consumers one stop shopping for health insurance, Exchanges will become a permanent part of each state's insurance market in 2014. The Exchanges will offer policies that can be easily compared; common rules for pricing and coverage; and the ability to shop and select a policy that best meets the purchaser's needs, including those receiving coverage through a small employer. States face a range of issues regarding the future of their insurance markets prior to the Exchanges' availability, but, first and foremost, will be a decision of whether they choose to manage their own Exchange or cede that role to the federal government.

American Health Benefit Exchange

As part of the Patient Protection and Affordable Care Act (PPACA), by January 1, 2014, each state is authorized to establish and coordinate an organized insurance marketplace known as an American Health Benefit Exchange. To purchase coverage in an Exchange, an individual must be U.S. citizen or legal immigrant who is not incarcerated and who does not have access to affordable employer-based coverage.

States are given the option of combining the individual and small group markets or creating a separate Small Business Health Options Program (SHOP) Exchange for small businesses. Until 2016, states have the option of limiting Exchanges to businesses with 50 or fewer workers. Beginning in 2017, states will be allowed to include businesses with more than 100 employees to purchase coverage from an Exchange.

A state may create several exchanges within its borders as long as each one serves a geographically distinct area. States may also join together to create multi-state exchanges.

While states will be allowed to combine the individual and small group markets, the option does not appear to be an attractive one for Texas as the state is sufficient in size to ensure significant risk pools for both markets. Additionally, many believe allowing larger groups (more than 100 employees) to "opt in" to the Exchange would increase the likelihood of adverse selection - a phenomenon that occurs when sicker individuals dominate a risk pool and drive up the cost of coverage for others.

Demonstrating Readiness for an Exchange

States are required to demonstrate by 2013 that they will have the structure in place to run their

own Exchange. If a state chooses not to operate an Exchange, its Exchange will be established and managed by the federal government. Because Exchanges will represent a sizeable block of a state's health insurance market, most states are expected to coordinate their own Exchanges in order to maintain their historic role in regulating insurance.

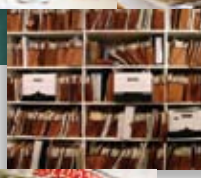
Premium Assistance for Individuals, Families and Small Businesses

Sliding-scale premium assistance will be available for individuals and families with incomes between 133 and 400 percent of the Federal Poverty Level in purchasing coverage through an Exchange. Small businesses with low-income workers will also be eligible for tax credits if they are providing coverage.

Health Benefits Offered in an Exchange

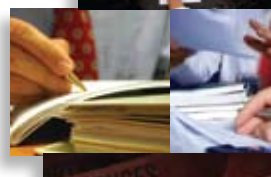
Health coverage offered in an Exchange must fall within five categories based primarily on actuarial value, or the estimated percentage of medical expenses to be paid by the insurer. **Those categories are:**

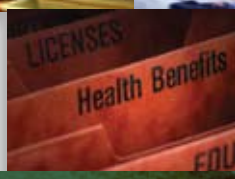
- ***Bronze:*** 60 percent of expense for "essential benefits package" paid by insurance
- ***Silver:*** 70 percent of expense for "essential benefits package" paid by insurance
- ***Gold:*** 80 percent of expense for "essential benefits package" paid by insurance
- ***Platinum:*** 90 percent of expense for "essential benefits package" paid by insurance
- ***Catastrophic:*** available for adults in the individual market who have not yet reached the age of 30 or who would otherwise be exempt from the requirement to purchase coverage due to premium prices exceeding eight percent of their income



All plans offered in the exchanges must include "essential benefits packages" that, at a minimum, include items and services within the following categories:

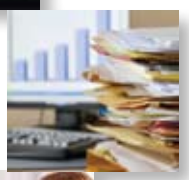
- Hospitalization
- Emergency services
- Ambulatory patient services
- Medical and surgical care
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

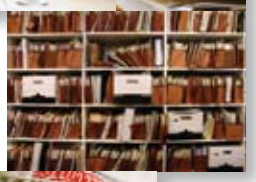


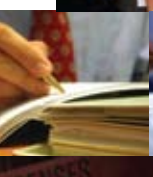
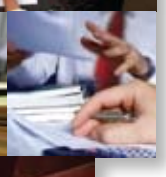
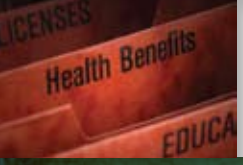


STATE HEALTH INSURANCE EXCHANGES: ORGANIZED MARKETS FOR HEALTH COVERAGE







Qualifying Health Plans

Only qualified health plans will be allowed to participate in an Exchange. In order to be certified as a qualified health plan, a plan must meet marketing requirements that ensure it will not discourage enrollment by sicker individuals, use a standard format to provide health plan benefit options, demonstrate it will have a sufficient number of providers (physicians and hospitals) within its network, include providers that serve low-income individuals, and be accredited on clinical quality measures.

Qualifying health plans offering coverage inside the Exchange will be required to offer at least one plan in the silver and gold categories.

Additionally, qualifying health plans as well as health plans operating outside of an Exchange will be required to meet other market reforms including:

- Guaranteed issue and renewability of coverage
- Prohibition on pre-existing conditions exclusions
- Prohibition on premium variation based on health status or gender
- Limits on premium variation based on age (3:1), geography, family size and tobacco use (1.5:1)
- Elimination of lifetime and annual dollar limits on essential benefits
- Coverage of certain preventive services without cost-sharing

Exchanges will be a Major Part of a State's Health Insurance Market

The Congressional Budget Office projects that approximately 24 million individuals will obtain their insurance through an Exchange by 2019, demonstrating the significant market role Exchanges will play within each state. Based on national estimates, as many as five million Texans may be eligible for participation in Exchanges by 2018.

Given the 2013 deadline for demonstrating readiness to create an Exchange, states are already developing strategic plans to put in place the structure necessary to avoid federal coordination of this important piece of their health insurance market. In Texas, the 2011 legislative session may be the best last chance for state lawmakers to influence how the state's health insurance market will operate in the American Health Benefit Exchange era.

Following is a series of key issues intended to assist state leaders in determining the role the state will play in managing its Exchange.

In Texas, the 2011 legislative session may be the best last chance for state lawmakers to influence how the state's health insurance market will operate in the American Health Benefit Exchange era

Should Texas Manage its Health Insurance Exchange?

Perhaps the most important factor a state will weigh in considering whether to manage its own Exchange will be the degree of regulatory authority and influence it wishes to maintain over its health insurance market. Since regulation of insurance is and will continue to remain predominantly a state function, surrendering this authority and role will not be easy. Additionally, since health insurance policies will continue to be regulated and sold outside of an Exchange, the potential for different and inconsistent rating and underwriting rules inside and outside the Exchange would be problematic. A federally managed Exchange will almost certainly result in two sets of regulations, creating confusion within the two markets, adding administrative costs and driving up premiums for consumers.

The separate regulatory tracks could also result in adverse selection issues developing as healthier individuals seek cheaper and higher deductible policies allowed outside the Exchange, leaving sicker individuals and higher premiums inside the Exchange. Clearly, a state-managed Exchange, rather than one overseen by the federal government, will be better positioned to align the rules inside and outside of an Exchange, thereby avoiding risk selection issues and regulatory inconsistencies.

Exchanges can be effective tools for states to use in advancing other health care priorities, including developing medical homes, encouraging creative benefit design by health plans, facilitating payment reforms, and targeting certain public health goals.

TAHP strongly supports that Texas retain control of its health insurance market by establishing and operating its own Exchange rather than ceding control to the federal government.

Funding an Exchange

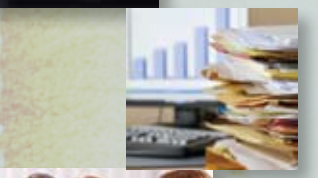
Federal grants for the planning and establishment of Exchanges were accepted by 48 states and the District of Columbia in September 2010. The federal government has indicated that it will provide implementation grants based on specific needs of each state through December 2014 when the Exchanges will be required to be self-sustaining. A popular assumption is that states operating their own Exchanges will likely consider the implementation of a transaction fee or policy surcharge to establish a funding stream for operations.

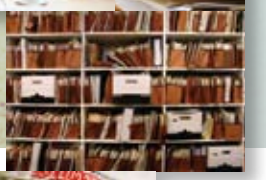
Governance and Structure of an Exchange

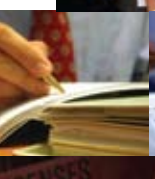
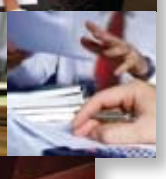
Perhaps the most important step a state will take in establishing its Exchange is identifying a governance structure that is open and transparent and is best positioned to foster the development of a robust and efficient marketplace. States are provided the option of placing their Exchanges in an existing or newly created state agency, a quasi-public agency or a nonprofit entity. Regardless of the model selected, Texas should ensure that the Exchange's governing board includes individuals with business, insurance, and actuarial experience. The governance structure should also ensure public accountability and operate in a transparent manner.

STATE HEALTH INSURANCE EXCHANGES: ORGANIZED MARKETS FOR HEALTH COVERAGE








At a minimum, Exchanges will be required to perform the following functions:

- operate a toll-free hotline to answer consumers' questions;
- certify health plans as being qualified to be offered in the Exchange;
- publicly disclose claims payment policies and practices, financial disclosures, enrollment data, denied claims, and rating practices;
- publish cost sharing and out-of-network payment information;
- create and maintain an Internet website where pricing and other plan information can be obtained;
- engage in plan rating for each plan in the Exchange based on quality and price of benefits;
- use a uniform enrollment form and a standardized format for presenting understandable health benefits plan options;
- inform the public about Medicaid, CHIP, and other similar state program enrollment eligibility as well as coordinate enrollment procedures;
- make an electronic calculator available to determine the actual cost of coverage; and
- grant certifications for those individuals who are exempt from the mandatory insurance requirement if there is no available plan through the Exchange or their employer.

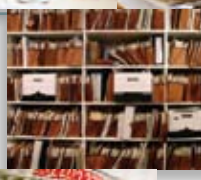
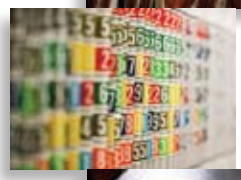
Exchanges must include a system that can evaluate and determine an individual's eligibility for Medicaid, CHIP and other public programs. This function will likely require an upgrade from the current IT systems utilized for eligibility determination and a need for coordination between public programs and the Exchange. The Centers for Medicare and Medicaid Services has announced its intent to provide enhanced federal funding at 90 percent for state expenditures for design, development, installation or enhancement of state Medicaid information systems through calendar year 2015. Enhanced funding will also be available at 75 percent for maintenance and operation of systems after 2015.

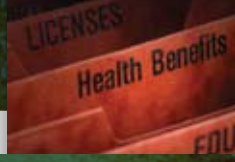
TAHP has established the following principles that can be critical in determining an Exchange's success in offering affordable coverage to consumers while fostering healthy competition among health plans within the state.

1. An Exchange should supplement, but not replace, existing markets.
2. The state should ensure a level competitive playing field to avoid adverse selection between the Exchange and the market outside the Exchange.
3. An Exchange should promote an efficient regulatory environment by separating market activity of the Exchange from state regulatory functions.
4. An Exchange should ensure meaningful choices for coverage by encouraging creativity among health plans inside and outside an Exchange while avoiding confusion among consumers.
5. An Exchange should promote and facilitate competition among all qualified health plans that seek to participate.
6. An Exchange's governance structure should be transparent and open to the public with representation of a broad range of stakeholders including consumers and individuals with business, insurance and actuarial experience.
7. An Exchange should ensure efficient operation and coordination with the state's public health programs including Medicaid and CHIP.
8. An Exchange should be established in a manner that limits disruption to employers currently offering coverage and that minimizes the negative impact upon consumers that often results when attempts are made to merge markets.





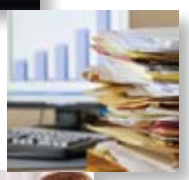
States Provided Broad Latitude in Managing Their Exchanges

Even though the basic framework for their creation is set forth in the PPACA, states are allowed significant flexibility in the creation, governance and management of their respective Exchanges. By using them to provide an organized market of affordable choices for health care, Exchanges can be effective tools for states attempting to provide affordable insurance options to those lacking access to employer-based coverage. Their design can also ensure Exchanges have the flexibility to facilitate competition among health plans on price and quality.

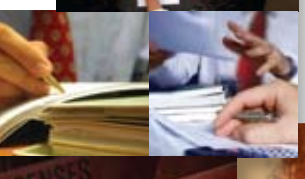
Texas should retain control of its health insurance market by opting to establish and run its own Health Insurance Exchange rather than ceding control to the federal government.

THE COMMON & LEGITIMATE ROLE OF RENTAL NETWORKS










Preserve Self-Funded Employer Health Plans

Networks of health care providers are developed by health plans to offer their enrollees access to the medical services they seek at reduced rates. Physicians, hospitals, clinical laboratories, and health care providers join these networks by agreeing to offer discounted rates in return for access to the health plan's members.

It is not uncommon for an individual with employer-provided coverage to live in an area that the employer's health plan network may not reach. In such an instance, it is common for the employer's health plan or health care administrator to contract with a network of physicians and hospitals that does have a presence in the area where the employee resides in order to offer that individual access to covered health care services. This arrangement involves the use by the health plan of what is referred to as a rental network.

The use of rental networks is a common practice that involves an established network of providers who agree to join the network and offer discounted fees for their services. In recent years, the legitimate use of rental networks has become confused with the inappropriate and unethical application of certain provider discounts in instances where there was not a contractual obligation between the provider offering the discount and the patient's health plan. These transactions involve what is known as a "Silent PPO" and result in the unscrupulous practice of provider discounts being given to entities with which the provider had no contractual arrangement.

A number of states, including Texas, have taken action to prohibit such activity through the adoption of "Silent PPO" laws. The Texas law (SB-130), passed by the 76th Texas Legislature, has resulted in enforcement action being taken by the TDI against entities engaging in the illegal conduct. Specifically, the law prohibits an insurer or third-party administrator from reimbursing a provider on a discounted fee schedule unless:

- the insurer or third-party administrator had contracted with the provider or with a PPO that contracted with the provider;
- the provider had agreed to the contract; and
- the insurer or third-party administrator had agreed to provide coverage for the benefits under the policy.

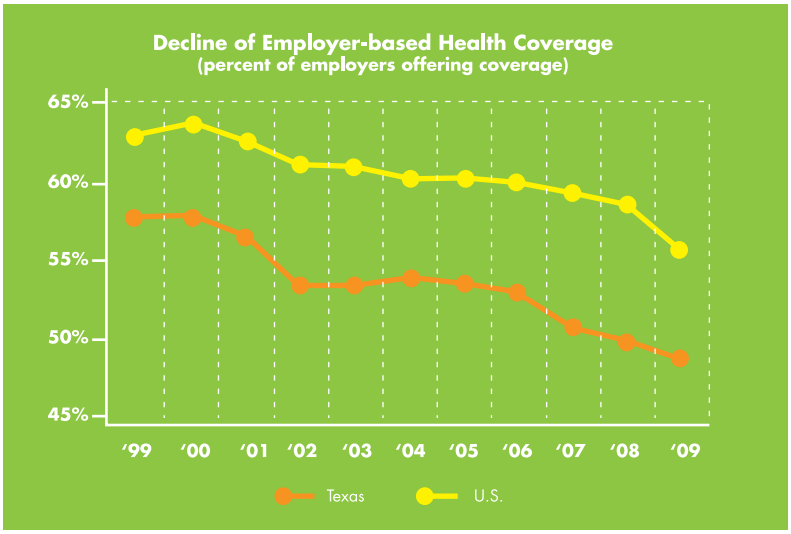
In recent years, there have been attempts in many states, including Texas, to use the "Silent PPO" issue as an attempt to further restrict the legitimate use of rental networks and to add state regulations to self-funded plans even though they are governed by federal ERISA laws and exempt from state oversight.

TAHP supports increased transparency in contracting and in the enforcement of the state's "Silent PPO" laws but opposes efforts to impede the proper use of rental networks and to place additional regulation on employer self-funded health plans.

Legislators should oppose efforts to circumvent long-established federal laws exempting self-funded plans from state regulation.

EXCLUSIVE PROVIDER ORGANIZATIONS OFFER EMPLOYERS COST SAVINGS & QUALITY CARE

Employer-based health coverage continues to be the primary source for health coverage in the country, but, according to the most recent Census report, the number of individuals receiving coverage from their employer dropped for the ninth consecutive year, from 58.5 percent in 2008 to 55.8 percent in 2009. The decline signals a potentially problematic trend for individuals and families who may be forced to purchase their own insurance or face federal penalties beginning in 2014 due to lack of coverage.



Source: U.S. Census Bureau

Employers say a slow economy is a principal factor for the decline, but there is broad agreement that rising medical costs are the primary driver causing many employers to eliminate employee coverage.

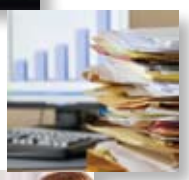
Recognizing that rising health care premiums are the result of the increasing cost of care, employers are stepping up their efforts to identify new approaches to contain the upward spiral of medical costs while still providing employees quality options. According to a study by Standard and Poor's, for the period of September 1, 2009-August 31, 2010, the average cost of providing health care services rose 7.32 percent compared to national inflation rate for the same period of 1.1 percent. The International Federation of Health Plans reports that Americans pay between 50-60 percent more than every other industrialized nation for medicines, technology, and professional services.

The rising per-unit cost of medical care, increasing pharmaceutical costs, and the increased and often over-utilization of health care are expected to continue as the primary drivers for continued increases in medical costs. The Centers for Medicare and Medicaid have projected that health care spending is expected to increase at an annual rate of 6.3 percent over the next decade and to total $4.6 trillion, or one of every five U.S. dollars spent by 2019.

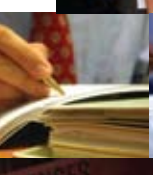
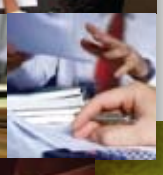
Employers know their challenge isn't about managing the health care premiums they pay. The real challenge they face is containing the underlying health care costs that drive premiums.

EXCLUSIVE PROVIDER ORGANIZATIONS OFFER EMPLOYERS COST SAVINGS & QUALITY CARE








Exclusive Provider Organizations (EPO) are the latest approach employers are utilizing in their quest to gain control of rising medical spending. EPOs offer employers an effective way to reduce their health care costs by striking a balance between the cost control measures of the traditional HMO model and the broad access offered by a Preferred Provider Organization (PPO).

In a traditional HMO, enrollees are able to choose from providers within the HMO's network. A Primary Care Physician (PCP) is usually selected from within the network to manage the medical care and specialist referrals for the enrollee. Individuals enrolled in an HMO often have lower out-of-pocket costs because care is delivered by providers within the HMO's network. Because the network offers all necessary medical care, enrollees are responsible for bills incurred for care received outside the network, with the exception of emergency care. HMOs have historically provided employers with the greatest cost savings due to their comprehensive design and the enhanced coordination of care they offer.

While PPOs offer enrollees the ability to use either an in-network or out-of-network provider, financial incentives to utilize in-network providers are a popular feature of this health plan model. With in-network providers agreeing to accept lower negotiated payment rates from the health plan, PPOs are able to offer enrollees reduced out-of-pocket expenses when in-network care is received. Conversely, enrollees assume higher out-of-pocket expenses if out-of-network care is obtained. In exchange for granting discounted rates, medical providers are guaranteed a steady stream of patients from the PPO.

EPOs combine the HMO's cost containment and the PPO's access features to offer employers predictable, manageable and reasonable costs while retaining quality health care.

EPOs combine the HMO's cost containment and the PPO's access features to offer employers predictable, manageable and reasonable costs while retaining quality health care. Enrollees are generally free to see any provider within the EPO network, which contains family and general practitioners as well as specialists. Enrollees need not select a PCP to coordinate their care, and referrals are not necessary to see a specialist. Providers selected to participate in an EPO network are often chosen based on their history of meeting certain quality standards in the delivery of health care. In some cases, EPOs have been projected to save employers between 20 and 30 percent of their health care costs.

In some states, EPOs are widely utilized by businesses with self-funded health plans. Currently, Texas law does not provide the EPO option to the state's employers. Doing so would add an important new tool to employers' ability to control health care costs and to continue offering health coverage to their employees.

The adoption of laws allowing for the operation of Exclusive Provider Plans (EPOs) in Texas will provide employers with the latest tool to control their health care costs and to continue offering quality care to their employees.

OBESITY: THE SILENT EPIDEMIC

The repercussions from America's expanding waistlines, super sizes and unhealthy levels of fat began sinking into the national psyche in 2001 when then Surgeon General David Satcher declared a nationwide obesity epidemic. Since then, obesity-related illness continues to inflict a staggering toll on our nation. A new study from the National Bureau of Economic research estimates obesity-related illnesses cost $168 billion and are responsible for 17 percent of U.S. medical costs.

Unless the state acts to prevent current trends from continuing, it is estimated that 75 percent - 3 out of every 4 adult Texans - could be obese or overweight by the year 2040.

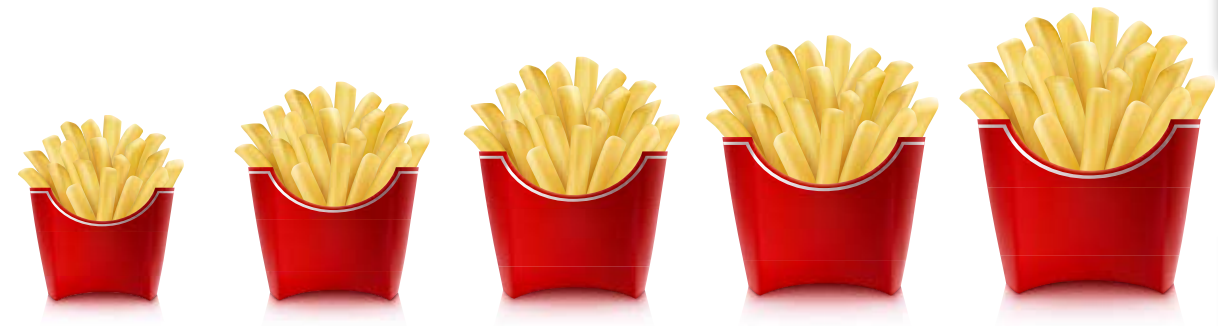
Nearly 67 percent of adult Texans were either obese or overweight in 2009, but the problem isn't limited to adults.[6] Fourteen percent of Texas high school students are obese.[7] Unless the state acts to prevent current trends from continuing, it is estimated that 75 percent - 3 out of every 4 adult Texans - could be obese or overweight by the year 2040.[8] The cost to Texas could quadruple from $10.5 billion today to as much as $39 billion.[9]

Nationally, two-thirds of adults and one-third of children living in the United States are currently obese or overweight. Last year, obesity rates rose in 28 states, including Texas, which moved from the 14th to the 13th rank for highest obesity in the nation.[10]

Adult obesity rates have doubled in just 30 years.[11] More alarming, the number of obese children ages 6-11 has quadrupled since 1970, while the number of obese adolescents ages 12-19 has tripled.[12] Regionally, with the exception of Michigan, the 10 states with the highest adult obesity rates are in the South.[13] Blacks and Latinos are disproportionately affected by obesity-related illness, with higher rates for diabetes, hypertension and heart disease.[14]

Obesity in Texas

Percentage of Texans obese by year

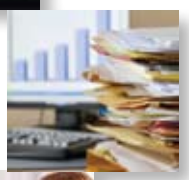


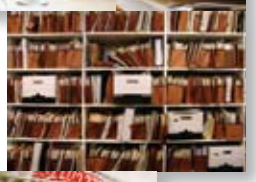
1988	1989-93	1994-98	1999-03	2004-09
Less than 10%	10-14%	15-19%	20-24%	25-29%

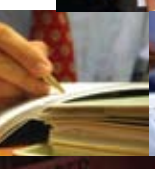
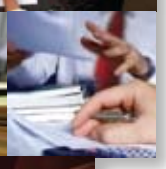
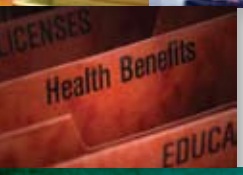
Source: CDC

OBESITY: THE SILENT EPIDEMIC







Root of the problem

Obesity occurs when individuals consume more calories than they burn. Experts blame sedentary lifestyles for these alarming trends, with increasing numbers of Americans sitting in front of a computer and fewer in occupations involving manual labor. Leisure time for children and adults often means watching even more hours of television or playing computer games.

According to the Mayo Clinic, high-calorie meals and unhealthy eating habits are other major culprits. Skipping breakfast and eating most calories at night are red flags, as are heavy consumption of fast food, oversized portions and free refills on sodas that are loaded with sugar but empty of nutrients.

Texas is not immune. The 2009 Texas Youth Risk Behavior Survey indicates 14 percent of Texas high school students are obese, with eating habits and behavior largely to blame. Only 20 percent reported eating fruits and vegetables five times per day during the seven days before the survey. Only 32 percent ate fruit or drank 100 percent fruit juices two times per day during the seven days before the survey, and one in three said they had consumed at least one soft drink or soda in the previous week.

Some 49 percent did not attend physical education classes in an average week when they were in school. Thirty-six percent watched television three or more hours per day on an average school day, and 25 percent used computers three or more hours per day on an average school day.

Why it matters

Obesity leads to chronic disease, adding to rising health care costs. Left untreated, obesity in adults increases the risk for:

- Coronary heart disease
- Type 2 diabetes
- Stroke
- Hypertension
- Cancer
- Premature death

The Human and Financial Toll of Obesity

Obese adults also pay a high price in human terms. Adult obesity is associated with social stigmatization, reduced quality of life and discrimination.[15] The Mayo Clinic says repercussions include depression, sexual problems, shame, low self-esteem, and social isolation.

Financially, disease associated with obesity accounted for 27 percent of increased medical costs in the United States from 1987 to 2001, notes The Centers for Disease Control. By 2006, people with obesity had medical costs that were $1,429 higher than persons with normal weight.

Obesity among full-time U.S. employees costs businesses an estimated $73.1 billion annually, according to research from Duke University, which considered:

- Employee medical expenditures,
- Lost productivity on the job due to health problems (presenteeism), and
- Absence from work (absenteeism).

The per-capita costs of obesity are as high as $16,900 for women with a body mass index (BMI) above 40 (roughly 100 pounds overweight) and $15,500 for men in the same BMI class. Presenteeism is the largest cost, accounting for as much as 56 percent of the total cost of obesity for women and 68 percent for men.

Solutions

Nationwide, governments and businesses are encouraging a range of behavioral changes, some with incentives.

The Trust for America's Health, a non-profit dedicated to disease prevention, recently released 70 recommendations for businesses and the federal government to combat childhood obesity, including:

- Standardized nutritional labeling for the front of food and beverage packages;
- Voluntary limits on marketing less healthy foods and beverages to children;
- Mandatory Federal Communications Commission rules on advertising foods to children if necessary;
- Promotion of physical activity through transportation plans encouraging walking and bicycles;
- Early childhood screening to improve nutrition and increase physical activity; and
- Better resources for school meals.

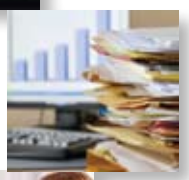
At work, businesses are increasingly looking beyond traditional educational tools for employees such as healthy food and nutritional guides. Innovative approaches include:[16]

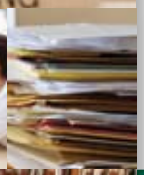
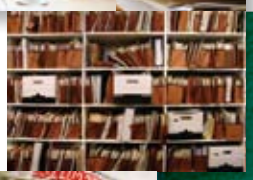
- Worksite exercise facilities or discounts for local fitness centers;
- Counseling for weight management and physical activity as part of health insurance benefits; and
- Availability in vending machines and on-site cafeterias of affordable and healthy foods and beverages.

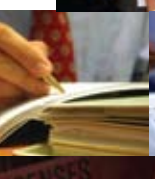
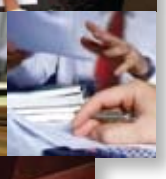
Inaction is costly, but Texas policymakers and schools have begun to fight back. Lawmakers during the 80th session passed legislation requiring schools to determine how to add 30 minutes of rigorous exercise to students' days outside the regular seven-hour day. Additionally, the 2008

OBESITY: THE SILENT EPIDEMIC






Texas School Health Profiles indicates that 75 percent of the state's schools taught 14 key nutrition and dietary behavior topics in a required course. Additionally, 80 percent taught a required PE course in all grades, and 48 percent offered opportunities for all students to participate in intramural activities or physical activity clubs.

To combat poor eating habits, 28 percent of Texas schools opted not to sell less nutritious foods and beverages anywhere outside the school food service program, while 19 percent always offered fruits or non-fried vegetables in vending machines and school stores, canteens, or snack bars.

While recognition of the epidemic is encouraging, public and private programs fall far short of the type of comprehensive strategies that will be required to reverse this alarming trend. Studies and statistics make clear, without meaningful commitment and action, the human and societal toll of obesity will overwhelm our health care system, reduce the quality of life for millions, and damage the economic vitality of the nation.

The implementation of meaningful strategies to address the growing epidemic of obesity can save lives, reduce chronic illnesses, reduce health care costs, and save taxpayer dollars.

The implementation of meaningful strategies to address the growing epidemic of obesity can save lives, reduce chronic illnesses, reduce health care costs, and save taxpayer dollars.

SMOKING IS NATION'S LEADING KILLER

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined, yet it is the single largest preventable cause of death and premature death in the United States.

Each year an estimated 443,000 Americans will die from smoking; another 49,400 will die from exposure to second hand smoke, according to the American Cancer Society. At this moment, an estimated 8.6 million Americans suffer from a smoking-caused illness.[17] Of all the kids who become new smokers each year, almost a third will ultimately die from it. In addition, smokers lose an average of 13 to 14 years of life because of their smoking.[18]

Each year an estimated 443,000 Americans will die from smoking; another 49,400 will die from exposure to second hand smoke, according to the American Cancer Society.

Tobacco can cause lung cancer, but it's also a risk factor for many other kinds of cancer, including cancer of the mouth, voice box (larynx), throat, esophagus, bladder, kidney, pancreas, cervix, stomach, and some leukemia. It's also linked to a number of other health problems, from heart disease to stroke.[19]

In financial terms, public and private health care expenditures related to smoking cost $96 billion a year, including $67.9 billion in taxpayer assistance for Medicare, Medicaid and other federal government health costs. That represents an annual bill of $616 per U.S. household. Texas currently spends almost $1.5 billion a year in Medicaid funding on direct tobacco-related health care costs. The cost of tobacco use to an employer averages $3,783 per smoker per year according to the U.S. Centers for Disease Control and Prevention.

Texas Health Costs Attributable to Smoking

2004 $6,251,000,000

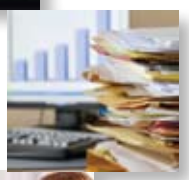
1998 $4,552,000,000

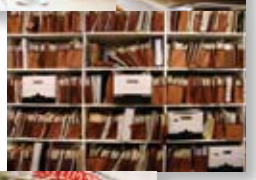
1993 $2,914,520,000

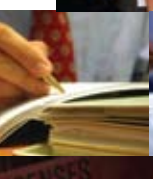
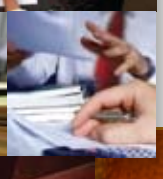
Source: CDC

SMOKING IS NATION'S LEADING KILLER








Additional smoking-related health costs caused by tobacco use include annual expenditures for health and developmental problems of infants and children caused by mothers smoking or being exposed to second-hand smoke during pregnancy or by children being exposed to parents smoking after birth (at least $1.4 to $4 billion).

Other non-healthcare costs from tobacco use include residential and commercial property losses from smoking-caused fires (about half a billion dollars per year) and tobacco-related cleaning and maintenance ($3 billion).[20]

Secondhand smoke also inflicts a significant toll on nonsmokers and society. It is estimated that the annual U.S. cost of excess medical care, mortality and morbidity from second-hand exposure is $10 billion.[21]

Smoke-free restaurants and bars are emerging as an effective strategy to combat the health risks posed by second-hand smoke. As of January 2010, more than 60 percent of the U.S. population, or more than 190 million people, live in areas that have passed strong smoke-free laws covering restaurants and bars – a figure that has nearly doubled in size in three years.[22]

In fact, numerous scientific and economic analyses show that smoke-free laws do not hurt restaurant and bar patronage, employment, sales, or profits. The Surgeon General's 2006 Report on The Health Consequences of Involuntary Exposure to Tobacco Smoke examined numerous studies from states and local communities across the country. The report concluded that, "Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry."

A comprehensive examination of smoke-free laws published in 2007 in the Cancer Journal for Clinicians concluded that "the vast majority of scientific evidence indicates that there is no negative economic impact of clean indoor air policies, with many studies finding that there may be some positive effects on local businesses."

These conclusions are further supported from data collected on ordinances passed in major Texas cities. The City of Houston's smoke-free ordinance (enacted September 1, 2007) had no adverse impact on restaurant or mixed beverage sales in its first nine months, according to a sales tax analysis released in February 2009.[23] Alcoholic beverage sales were not affected by the El Paso smoke-free ordinance, according to a study examining the relationship between the ordinance and bar revenues conducted by the Texas Department of State Health Services and the U. S. Centers for Disease Control and Prevention.[24]

The 2008 Zagat Survey: America's Top Restaurants of 132,000 Americans noted that, "The verdict on smoking is overwhelming with 77% of diners saying they'd eat out less if smoking were permitted in local restaurants, and only 2% saying they'd dine out more."

Adopting a statewide smoking ban will save lives, improve public health, reduce health care costs and save taxpayer dollars.

REFERENCES

1 Texas Medicaid and CHIP in Perspective, Seventh Edition, Texas Health and Human Services Commission, January 2009

2 Texas Health and Human Services

3 Texas Health and Human Services, Legislative Presentation by Tom Suehs, Executive Commissioner, June 2010

4 Center for Medicare and Medicaid Services, National Health Expenditure Date

5 Ibid

6 "Texas Overweight and Obesity Statistics," Texas Department of State Health Services, May 2010.

7 Centers for Disease Control and Prevention

8 "Texas Overweight and Obesity Statistics," Texas Department of State Health Services, May 2010.

9 Ibid

10 "F as in Fat: How Obesity Threatens America's Future 2010," Trust for America's Health and The Robert Wood Johnson Foundation.

11 Ibid

12 Ibid

13 Ibid

14 Ibid

15 "Vital Signs: State-Specific Obesity Prevalence Among Adults – United States, 2009," Centers for Disease Control and Prevention, August 2010.

16 Preventing Overweight and Obesity - Prevention Programs At The Work Site, http://bit.ly/dMjuL

17 http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf

18 Ibid

19 Ibid

20 Ibid

21 "Economic Effects of Environmental Tobacco Smoke," Society of Actuaries & Georgia State University –Donald Behan, Michael Erikson, Yijia Lin, August 2005.

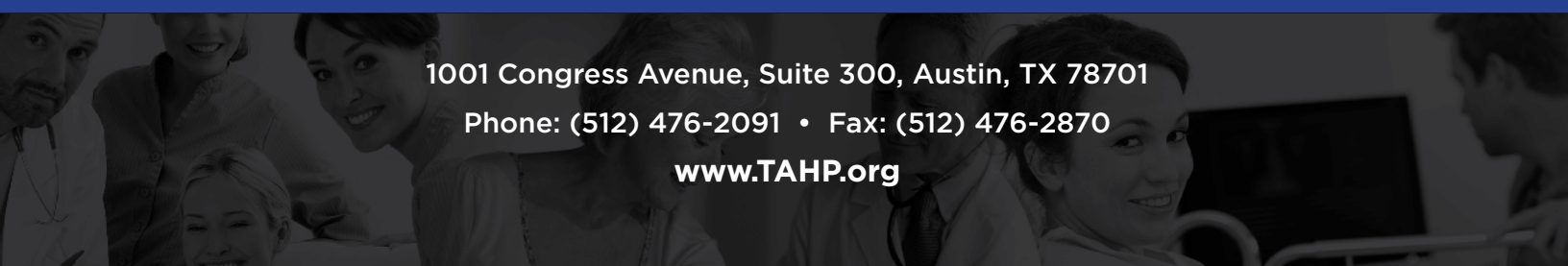
22 http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf

23 www.smokefreetexas.org

24 Ibid

TAHP

Texas Association of Health Plans



1001 Congress Avenue, Suite 300, Austin, TX 78701

Phone: (512) 476-2091 • Fax: (512) 476-2870

www.TAHP.org