TAHP
The Texas Association of Health Plans

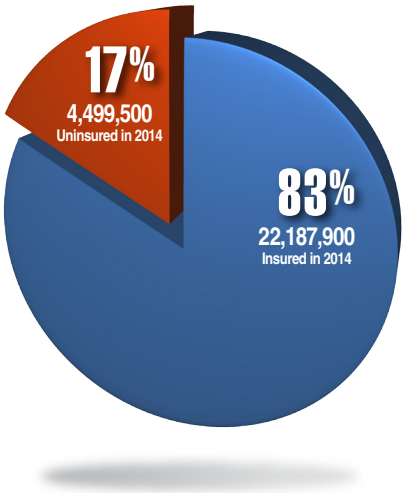
Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Health Coverage in Texas

Why Health Coverage is Important

Health coverage plays an essential role in ensuring healthy families and healthy communities. As of 2014, 83 percent of Texans (or more than 22 million) have some form of health coverage, while 17 percent (or nearly 5 million) do not have health benefits.[1]

Texas Health Coverage and the Uninsured in 2014



Source: Kaiser Family Foundation report on the Census Bureau's March 2015 Current Population Survey "CPS: Annual Social and Economic Supplements"

Fast Facts on Health Coverage

- **25 percent of adults** without coverage went without care in 2013 because of its cost.[2]
- **More than half of uninsured adults (55%)** do not have a regular place to go when they are sick or need medical advice.[3]
- **Nearly a quarter of uninsured adults** say they did not take a prescribed drug in 2013 because they could not afford it.[4]
- Health coverage better protects individuals against medical debt, which is the **number one cause of personal bankruptcy for Americans.**[5]

1 Source: Kaiser Family Foundation report on the Census Bureau's March 2015 Current Population Survey "CPS: Annual Social and Economic Supplements"
2 Source: Kaiser Commission on Medicaid and the Uninsured analysis of 2013 National Health Interview Survey data
3 Source: Kaiser Commission on Medicaid and the Uninsured analysis of 2013 National Health Interview Survey data
4 Source: National Center for Health Statistics 2013
5 Source: https://www.nerdwallet.com/blog/health/2014/03/26/medical-bankruptcy/

Profiles of the Insured and Uninsured

People with health coverage are generally healthier individuals who have regular doctors and take advantage of key preventive health care services. Insured individuals are also better insulated from financial hardship and medical debt because their coverage protects them in the event of a serious illness or injury. This combination of greater physical health and financial security generally yields a higher quality of life.

Those who lack health coverage face a number of challenges, including barriers to receiving important preventive care services such as blood pressure tests, cholesterol checks, and cancer screenings. As a result, these individuals have a greater chance of being hospitalized for conditions that could have been prevented, as well as an increased risk of being diagnosed in later stages of diseases such as cancer. Individuals who lack health coverage are also less likely to receive all the services that are recommended when injured or newly diagnosed with a chronic condition.

The uninsured face higher rates of conditions such as hypertension, diabetes, and stroke than the insured, and their general health after age 50 declines more significantly than those with health coverage.

Today, federal law requires most people to have a health insurance plan that meets minimum federal coverage standards or pay a tax penalty. Health benefit plans provided by employers and most state or federal government health plans (Medicare, Medicaid, CHIP, TRICARE, and some veterans' health programs) will usually satisfy the requirement.

Health care coverage makes a difference in whether people get necessary medical care, when they get it, where they get their care, and ultimately, how healthy they are in the long-term.

What is Health Coverage?

A health plan or health coverage refers to a specific package of benefits that helps individuals cover their health care costs. It is typically offered by an insurance company, an employer who offers a self-funded plan, or a government-sponsored program.

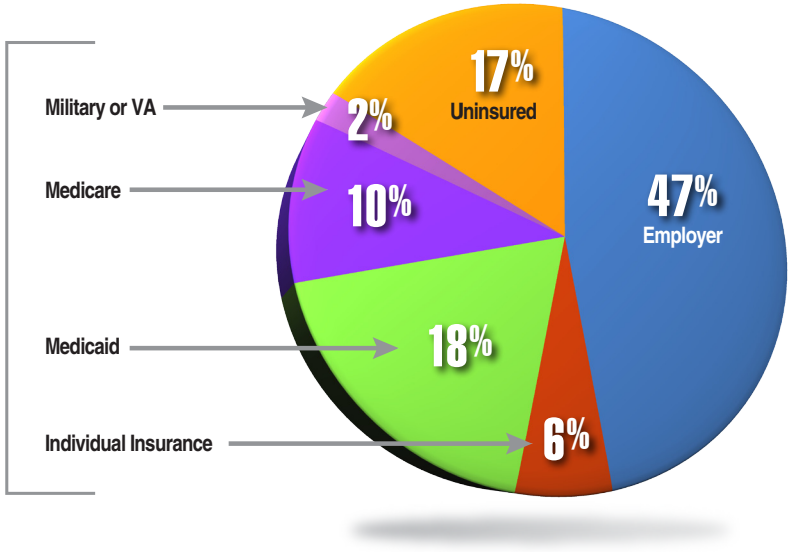
Health insurance coverage helps protect people from high medical costs. An individual or family buys a plan or policy, often through an employer, and pays a monthly premium payment, and the insurer contractually agrees to pay a portion of covered medical costs. Most plans cover doctors' appointments, emergency room visits, hospital stays, and medications.

The idea behind insurance is simple: Medical care can be expensive. Most people can't pay for it all out of their own pockets. But if each person in a large group of people pays a fixed amount every month (whether they need medical care at that time or not), the risk is spread out over the whole group and each person is protected from the risk of high health care costs.

Types of Health Coverage: Private vs. Public

As of 2014, about 83 percent of Texans had some form of health coverage, with more than 13 million individuals covered by private insurance and more than 8.5 million covered by public insurance, such as Medicare or Medicaid.

Where Texans Got Their Insurance in 2014

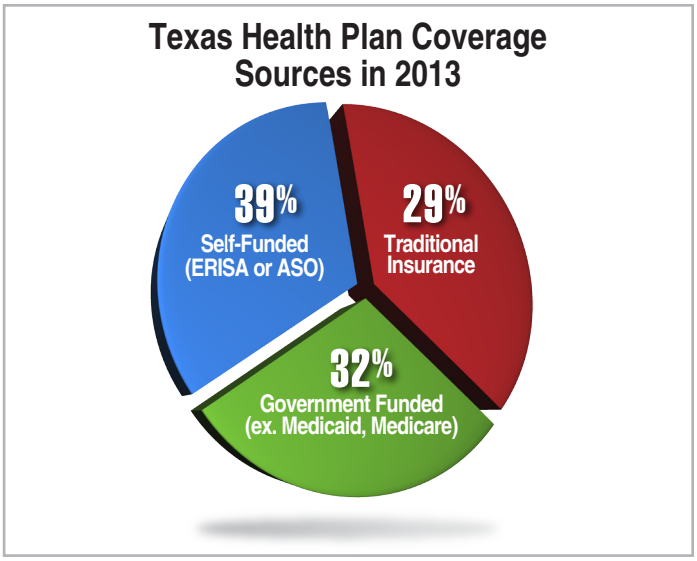


Source: Kaiser Family Foundation report on the Census Bureau's March 2015 Current Population Survey "CPS: Annual Social and Economic Supplements"

Types of Private Insurance

Traditional Insurance (Commercial Insurance)

The most traditional form of private health insurance is called a fully insured plan, or more commonly, commercial health insurance. In a commercial/fully insured plan, the policyholder pays a premium to an insurance company, and the insurance company assumes most of the risk for covered health care services. Commercial health insurance includes both the employer group market and individual market. In employer group coverage, the employer, rather than the individual, is the policyholder and premium costs are usually shared by the employer and enrolled employees. Traditional insurance is the type of coverage that is regulated by the Texas Department of Insurance (TDI). 4.5 million Texans receive coverage through the traditional insurance market.



Source: Texas Department of Insurance

Self-Funded Insurance Plan (ERISA Plan)

About 39 percent of Texans with health benefits are covered by **"self-funded"** plans in which plan sponsors (usually employers) fund the employee benefit plans and bear the risk of loss, rather than buying coverage from an insurance company or HMO. Covered benefits may vary by plan and employer. Employers who self-fund their health plans may require employees to contribute to the cost of the plan.

Self-funded plans often use insurance companies or other third-party administrators (TPAs) to help administer the plan. For example, the plan may contract to use an insurance company's provider network or claims processing system. The contracts between the self-funded plans and the administering companies are often referred to as "administrative services only" (ASO).

Employers who choose to self-fund as an alternative to the traditional fully insured approach generally do so as a means to better manage rising health care costs. Self-insuring a benefit program can provide cost savings, as well as an opportunity to significantly impact plan design and utilization controls. Employers who self-fund are not subject to state health insurance premium taxes, which are generally 2-3 percent of premiums. Self-funded plans are primarily regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) and are not governed by state insurance laws or regulators. As such, self-funded plans are often called **"self-insured plans"** or **"ERISA plans"** (ERISA does not apply to church or government health plans, such as the Employees Retirement System of Texas). TDI does not regulate self-funded ERISA plans.

Public Insurance

Public insurance is government-sponsored health coverage typically for individuals who are low-income, elderly, or disabled. The two largest sources of government coverage are Medicaid and Medicare.

Approximately 8 million Texans are covered by **public health coverage plans** including Medicaid and CHIP, Medicare, and VA and military plans.

Public health insurance programs, often considered a "safety net," have been an important avenue of access to coverage. In 2013, Medicaid and CHIP covered 19 percent of consumers nationwide under the age of 65 and were the largest sources of insurance for children in the U.S., covering 78 percent of low-income children. While government programs have traditionally focused on low-income women, children, the elderly and individuals with disabilities, the ACA encouraged states to expand government coverage to also include low-income families and adults. So far, 30 states and the District of Columbia have opted to expand access to coverage in Medicaid. Texas is one of 20 states that has chosen not to expand its Medicaid program.

Understanding Commercial Health Insurance

The State of Texas regulates commercial health insurance through TDI. In commercial health insurance there are **three primary types of markets:**

- *Individual Health Plans*
- *Small-Employer Group Plans*
- *Large-Employer Group Plans*

Commercial Insurance Markets: Individual vs. Group Health Plans

Individual Health Plans

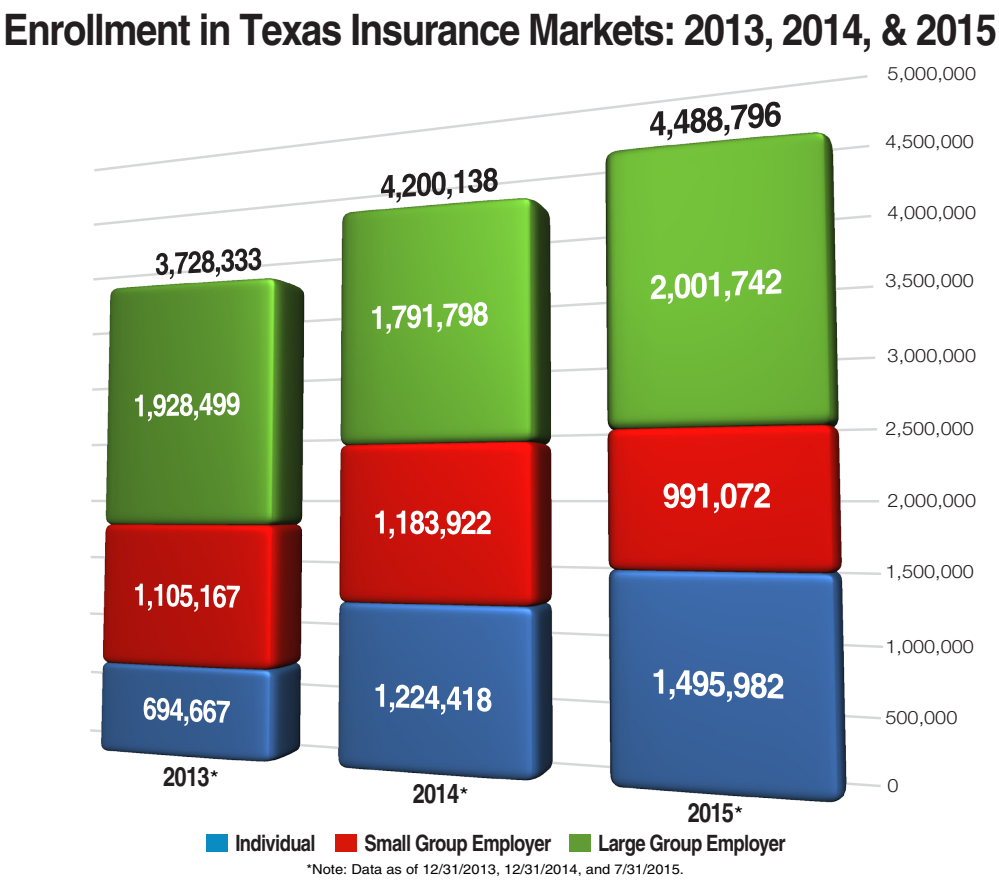
Some individuals choose to purchase health coverage directly from an insurance company, through an agent or broker, or in the federal marketplace (exchange). These policies can cover the individual only or can include a spouse and dependents. Individual coverage is often purchased by the self-employed. Roughly 1.5 million Texans are covered in the individual market.

Typically, you can only buy an individual health plan during an open-enrollment period. This means you might not be able to buy insurance year round and shouldn't wait to buy coverage until you need it.

Health insurance companies are required to sell a plan to anyone who applies during the open enrollment period. Individuals will not be denied coverage or charged more because of a preexisting condition, disability, other health factor, or gender.

Under state and federal laws, health plans must offer a certain set of benefits, called state-mandated benefits and **federal essential health benefits.**

Individual plans are categorized as either **bronze, silver, gold, or platinum.** These categories refer to the "actuarial value," which is the average amount of expected costs covered by the plan. A bronze plan pays, on average, at least 60 percent of overall health care costs. A silver plan pays 70 percent, a gold plan pays 80 percent, and a platinum plan pays 90 percent. The percentages are based on plan payouts as a whole and may not necessarily reflect an individual's exact responsibility. Federal law limits the amount consumers have to pay out-of-pocket under these plans to $6,600 for an individual or $13,200 for a family in 2015.

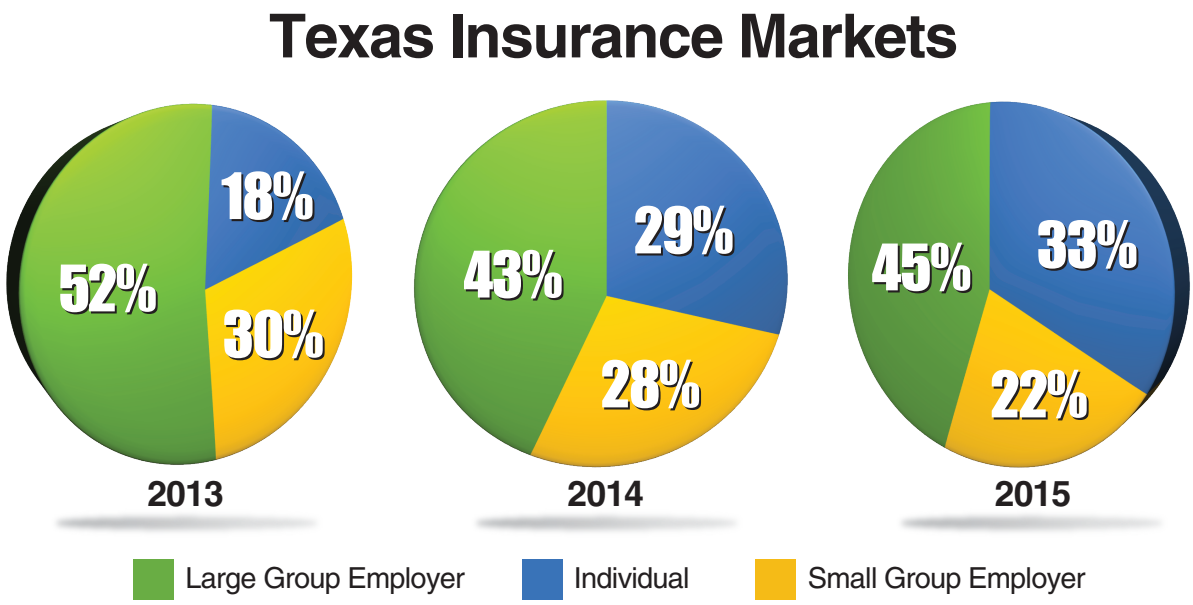


Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman, Dec. 2015

Group Health Plans

Most Texans with health care coverage have an employer-sponsored plan. Employers often offer **group health plans** as part of an employee benefits package. Employers and groups that offer health coverage aren't required to contribute toward plan premiums, but most do for employees.

State and federal laws for group plans differ depending on the size and nature of the group. Three million Texans are covered by group health plans.



Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman, Dec. 2015

Small-Employer Plans

Small-employer plans are a type of group plan provided by businesses that have between two and 50 employees. Federal law doesn't require small employers to offer health plans to employees.

A small employer may decide to offer coverage to only full-time employees (those who work 30 hours or more per week) or to both full-time and part-time employees. Employers may not discriminate when deciding who they want to consider eligible for coverage. One million Texans are covered through small employer plans.

State and federal law prohibit insurance companies from refusing to sell a policy to a small employer solely because of the employees' health status. Federal law prohibits companies from basing premium rates on members' health status. Companies may only base rates on age, geography, and tobacco use. Small-employer plans may not have lifetime or annual dollar limits on coverage, and they cannot deny coverage because of preexisting conditions or health history.

Large-Employer or Other Large Group Plans

Large-employer plans are offered by businesses with more than 50 employees.

Federal law does not require large employers to offer insurance but does have a penalty for those who choose not to offer coverage. Two million Texans are covered through large group plans.

Federal law exempts large-group plans from the essential health benefits and rating requirements that apply to individual and small-group plans. Like other comprehensive health plans, however, large-employer plans must provide free preventive services (no member cost-sharing). Depending on age and gender, employees may get check-ups, blood pressure and diabetes testing, contraceptives, mammograms, cancer screenings, and flu shots with no co-payment or coinsurance required.

Large-group plans may not have lifetime or annual dollar limits on coverage, and they cannot deny coverage because of preexisting conditions or health history.

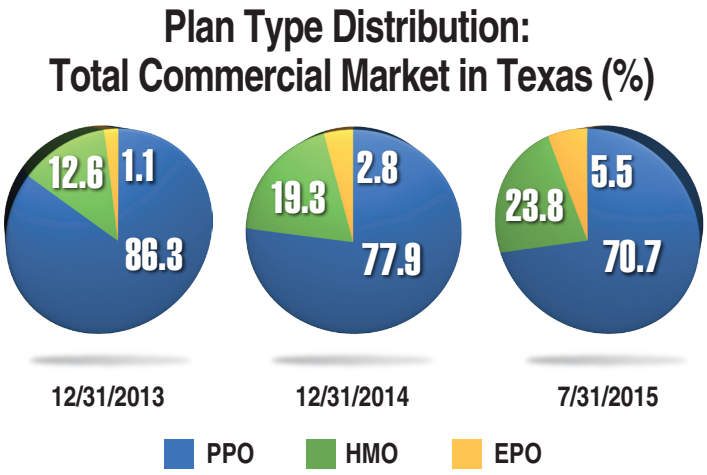
Commercial Insurance: Types of Products

There are typically three types of products available through commercial insurance in the State of Texas: **HMOs**, **PPOs**, and **EPOs**.

PPOs are the most purchased commercial product in Texas. Consumers typically pay higher monthly premiums for PPOs because they cover some portion of out-of-network costs and do not require a referral.

HMOs provide lower monthly premiums because coverage is limited strictly to doctors or hospitals that are in network and requires referrals.

An **EPO** is a relatively new product in the Texas market. It's similar to an HMO because it has restrictions, and the premiums are more affordable. But it doesn't require a patient to choose a primary care physician.



Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman; Addendum, April 2016.

Preferred Provider Benefit Plans (PPO)

A PPO is a network health plan offered by an insurance company. PPOs typically have a higher premium because these plans provide coverage both in and out of network.

Although you can usually go to any doctor you choose, your out-of-pocket costs will be lower if you use doctors in the PPO's network. You will typically pay more if you receive care from a physician or hospital that is not in the health plan's network because the health plan will cover a lower percentage of costs.

A PPO does not require referrals by your primary care doctor for specialty care.

Doctors and hospitals in a PPO's network have agreed to charge a discounted price for services to the PPO's members. Out-of-network doctors and hospitals haven't agreed to the discounted prices and often charge more than what your PPO plan will pay for your care.

Health Maintenance Organizations (HMO)

HMOs generally have lower monthly premiums because coverage is limited to doctors and hospitals that are in network. Exceptions apply and HMOs do provide coverage in emergency situations and when a network provider is not reasonably available. A patient who goes outside the network for something that is not an emergency likely will have to pay the entire bill.

HMO members usually choose a network primary care physician (PCP) and may be required to obtain referrals from their PCPs for specialty services . For this reason, the PCP may be referred to as a "gatekeeper." HMO plans are often less expensive because of the limited benefits for non-network services.

Point of Service Plans (POS)

A point-of-service plan offers out-of-network benefits to supplement the in-network benefits provided by an HMO. The point-of-service option allows members the flexibility to see out-of-network doctors in exchange for paying more out of pocket. Members will still be required to choose a primary care physician but may go to out-of-network doctors without a referral. However, if members use doctors and hospitals that aren't in their HMO's network, they'll have to pay more out-of-pocket for their health care. A point-of-service plan may exclude the option for out-of-network care for some medical conditions. Point-of-service coverage is usually offered as an add-on to the plan - called a rider - for an additional fee. If an employer only offers an HMO plan, the law requires the HMO to make a POS option available.

Exclusive Provider Benefit Plans (EPO)

EPOs are a third type of plan that has become available in the Texas commercial insurance market in recent years.

EPO plans are similar to PPOs. They negotiate agreements with doctors and hospitals to provide care to their members at a discounted rate. You must use doctors and hospitals in the EPO's network.

The primary difference between EPOs and PPOs is that PPOs will typically pay some of the cost of your care if you go to doctors or hospitals outside of their networks, while EPOs will not. There are exceptions for medical emergencies and for medically necessary services that are only available outside the EPO network.

EPO plans do not require PCP assignment but may have some "gatekeeper" referral requirements.

Miscellaneous

What is a High Deductible Health Plan?

A High Deductible Health Plan (HDHP) is a health insurance plan that contains certain requirements with respect to deductibles and out-of-pocket expenses. The deductibles are generally higher than those for a standard health insurance plan, and out-of-pocket expenses are generally not covered (up to a maximum amount) until the annual deductible is reached. Due to the nature of these health plans, the premiums are generally lower.

Most HDHP plans provide exceptions and cover some preventive care expenses without applying the deductible, such as periodic health evaluations, well-baby/well-child care, immunizations, tobacco cessation and weight loss programs, and certain screening devices.

What is an HSA?

Health savings accounts (HSAs) are like personal savings accounts, but the money in them is used to pay for health care expenses. You — not your employer or insurance company — own and control the money in your HSA. The money you deposit into the account is not taxed. To be eligible to open an HSA, you must have an HDHP.

HSAs and HDHPs were created as a way to help control health care costs. The idea is that people will spend their health care dollars more wisely if they're using their own money. In addition, doctors and other health care providers will have an incentive to lower their rates because they're competing for business.

Your employer may offer an HSA option or you can start an account on your own through a bank or other financial institution. To qualify, you must be under age 65 and carry a HDHP. If you have a spouse who uses your insurance as secondary coverage, he or she also must be enrolled in a HDHP.

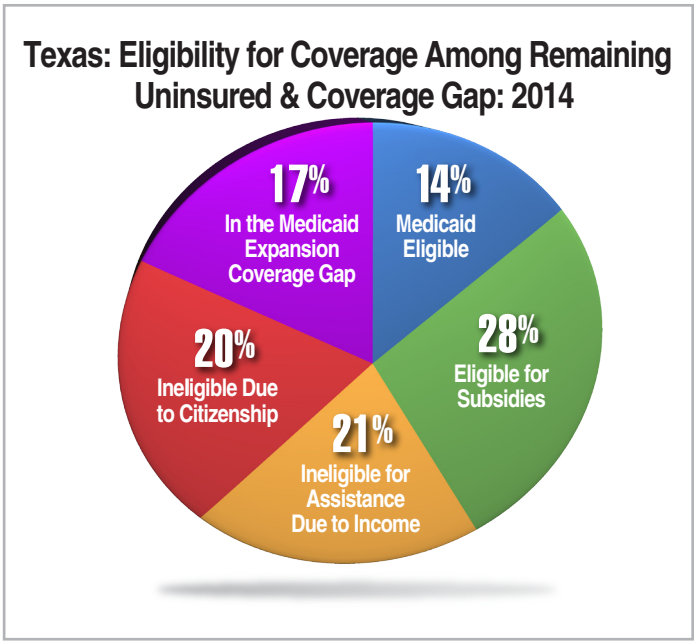
This high-deductible health plan must be your only health insurance — you can't be covered by any other health insurance. However, having dental, vision, disability and long-term care insurance doesn't disqualify you from having an HSA.

A Closer Look: Insured & Uninsured Texans

As of 2014, 83 percent of Texans (or more than 22 million) had some form of health coverage, while 17 percent (or nearly 5 million) do not have health benefits.

The majority of the uninsured are part of low-income working families. Roughly 33 percent of the remaining uninsured in Texas are eligible for government assistance through marketplace subsidies or Medicaid, but they have not taken advantage of those programs.

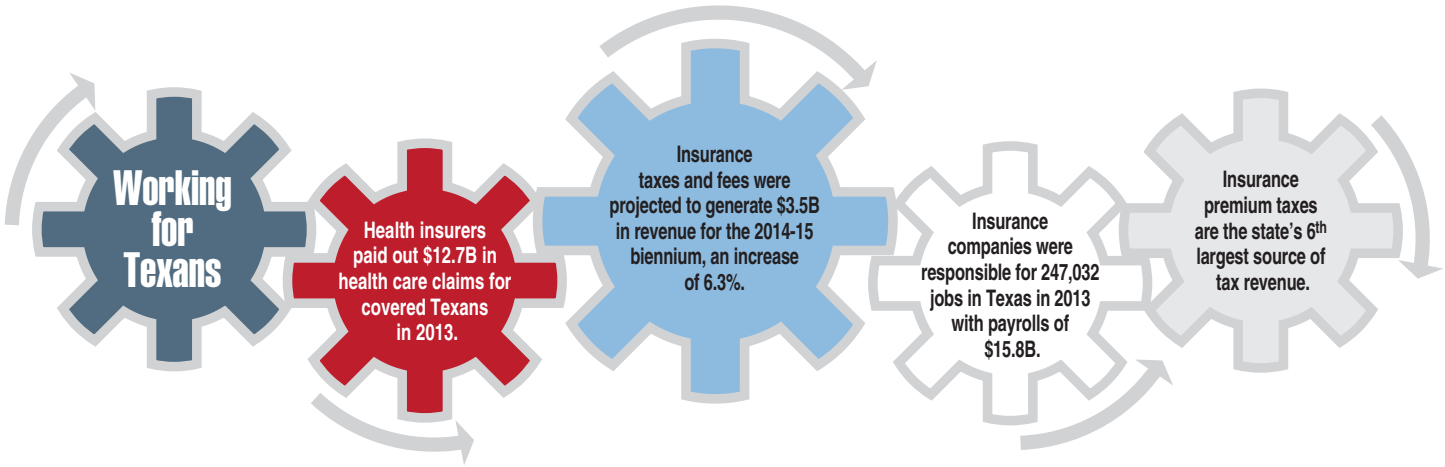
Approximately 17 percent of uninsured Texans are in the "coverage gap". One of the major coverage provisions in the ACA was the expansion of Medicaid to cover everyone up to 133 percent of the federal poverty line — covering individuals whose incomes were too low for the subsides in the exchange. Medicaid expansion was supposed to be mandatory for all states, but the Supreme Court ruled that it was optional for states. Many states have chosen not to expand, leaving a large number of low-income uninsured without any assistance for coverage. Texas is one of 20 states that have chosen not to expand Medicaid. Because the ACA envisioned individuals that were low-income receiving coverage through Medicaid, it does not provide subsidies to people below 100% of the federal poverty limit. As a result, many adults who live in states that chose not to expand Medicaid, fall into a category referred to as the coverage gap. The "coverage gap" includes individuals whose incomes are not high enough to receive a federal subsidy and too high to qualify for Medicaid.[6]



Source: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels and 2014 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)

Health Insurance: Working for Texans

In addition to playing an integral role in the overall health of Texans, the health insurance industry in Texas yields positive results for the economy, creating jobs and generating economic revenue to fund other critical initiatives.



6 Source: Kaiser Family Foundation report on the Census Bureau's March 2015 Current Population Survey "CPS: Annual Social and Economic Supplements").

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