Texas Health Insurance Risk Pool Expansion Options

Texas Department of Insurance

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TEXAS HEALTH INSURANCE RISK POOL EXPANSION OPTIONS

A Study of the Texas Health Insurance Risk Pool Under Senate Bill 467, 78th Texas Legislature

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EXECUTIVE SUMMARY

Senate Bill 467 enacted by the 78th Texas Legislature directs the Texas Department of Insurance (TDI) to identify options for expanding the Texas Health Insurance Risk Pool (herein referred to as THIRP or Pool). Specifically, the statute directs TDI to:

> "study how to expand eligibility in the pool to include a person who: (1) does not receive health insurance coverage through the person's employer; and (2) is unable to obtain health insurance coverage on the open market. The study must consider ways to accomplish the expansion of eligibility while minimizing cost shifting from employers to the pool."

This report provides an overview of the Pool, and the significant role it plays in increasing Texans' access to individual health insurance, as required under federal law. The report also discusses the small employer health insurance market and the challenges of enacting changes that comply with the federal Health Insurance Portability and Accountability Act (HIPAA) provisions designed to protect small employers and employees.

TDI explored several options for expanding coverage, including: a) small employer buy-in options; b) risk pool eligibility changes; c) federal funding opportunities; d) assessment methodology changes; and e) reductions in premium costs to improve affordability. This report does not, however, recommend which of these options should be enacted as that decision is the prerogative of the Legislature.

The report points out the sensitive environment in which the group and individual health insurance market operates. It is important to note that one relatively minor change can have significant, unexpected consequences in future years. This phenomenon is particularly true of the small employer market, which is extremely sensitive to even subtle changes that affect rating or participation conditions. Any changes should be considered in the total context of complex insurance market dynamics, and with an understanding of how the change may affect the careful balance between affordability and accessibility.

Texas Health Insurance Risk Pool Expansion Options

Health insurance for most privately insured Texans is provided as a benefit offered by employers. In 2003, an estimated 11.4 million Texas workers and their dependents were covered by employment based health care coverage. Individuals who are not employed, who are self-employed, or who work for an employer that doesn't offer group coverage must obtain insurance through some other means. In some cases, individuals may be able to enroll under a plan offered by a spouse's employer, but if an employer group plan is not available, they may turn to the individual insurance market or a member-only association plan for coverage. Approximately 1.2 million Texans were covered under an individual insurance plan in 2003.

Unfortunately, not all people who apply for individual coverage are accepted. Unlike most group health insurance applicants, insurers collect detailed health information from individual applicants and use that information to decline coverage of any person that does not pass their underwriting requirements. A person with a serious or chronic health problem will most likely find that individual health insurers will decline to cover them, deeming them "uninsurable" in the commercial market.

The legislature created the Texas Health Insurance Risk Pool (referred to as THIRP or Pool) to provide an alternative for those Texans who cannot obtain individual coverage from the commercial insurance market due specifically to pre-existing health problems. Operational since 1997, the Pool plays a significant role in ensuring all Texans have access to health insurance. Despite the relative success of the THIRP, however, many uninsured Texans that would like to enroll in the Pool cannot afford coverage, or may be ineligible for coverage.

Senate Bill 467, enacted by the 78th Texas Legislature, directed the Texas Department of Insurance (TDI) to study the Pool to identify options for including more people in the Pool. The Legislation specifically states that the study of expansion options include a person who does not receive insurance through their employer and is unable to obtain health insurance on the open market. Under the current laws and eligibility requirements, many of the uninsured who cannot obtain health insurance from the commercial insurance market would already be eligible for THIRP coverage, but the cost of coverage limits their access.

In discussing SB 467 with the legislative sponsors, TDI determined that it was appropriate to also evaluate options for broadening enrollment criteria or expanding enrollment to include certain groups. As such, while TDI's study is somewhat broader than the legislation indicates, the chosen approach allows a more comprehensive evaluation of expansion options. Specifically, this report discusses the following concepts that could lead to expanded enrollment in the THIRP:

- small employer buy-in options;
- Pool eligibility changes;
- federal funding opportunities;
- reductions in premium costs to improve affordability; and
- assessment methodology changes.

Texas Health Insurance Risk Pool Overview

Although the vast majority of workers and their families obtain coverage under a group plan offered by an employer, self-employed individuals or others without access to a group plan can purchase individual coverage from many insurers and HMOs. Individual health insurers and HMOs, however, carefully screen applicants and will likely refuse to cover them if they have a chronic disease or health condition, or have had a health problem in the past. Health insurance risk pools were established to offer an alternative for these individuals, and are an important component of the private insurance market. Today, more than 30 states have health insurance risk pools for individuals who otherwise would likely be uninsured.

The THIRP was initially created, but not funded, by the Texas Legislature in 1989. In 1997, the Legislature authorized funding for the Pool and designated the Pool to serve as the state's alternative mechanism for providing guaranteed access to health insurance in the individual market as required under the federal Health Insurance Portability and Accountability Act (HIPAA). Since 1997, the Pool has served as the "insurer of last resort" for thousands of Texans who need health insurance but have pre-existing health conditions that make them uninsurable in the commercial market. With more than 25,000 Texans insured in 2003, the THIRP is one of the largest pools in the country.

THIRP Funding

Although all states' risk pools serve the high-risk population, the operational and financial provisions vary significantly by state. The Texas Pool operates under the direction of a nine member board, appointed by the Commissioner of Insurance. The Board appoints an Executive Director and selects an insurer or third party administrator to serve as the Pool Administrator. For the most part, the THIRP operates as any other insurance plan, enrolling individuals who pay premiums for coverage. However, because the Pool includes individuals who incur higher than average claims, the premium cost is more expensive than standard coverage. By law, the Pool rates cannot exceed 200 percent of the standard rate for commercial individual health insurance. Although the Board initially set them lower, Pool rates have gradually increased and are now at the statutory cap.

Even with the higher insurance rates, Pool premiums do not cover the total claims costs; this is true in all state risk pools, not just Texas. By definition, pool members are "high risk individuals" with pre-existing health conditions that often result in costly medical care. Although pool premiums are higher than rates in the commercial market, pool expenses must be augmented with other funding to meet claims needs as well as to keep premiums affordable for enrollees. In Texas, excess losses above and beyond the premiums collected are paid through annual and interim assessments on insurers and HMOs, based on the percentage of health premium written in Texas by each company. According to the Texas Health Insurance Risk Pool 2003 Annual Report, the average monthly premium was $437 ($478 in 2004). Total claims paid in 2003 were $171 million. Insurance assessments paid by 210 health insurers and HMOs to make up the difference between premiums and losses for calendar year 2003 totaled $62.6 million.

Benefits and Eligibility Requirements

Benefits under THIRP are comparable to those provided under a typical individual plan (see Appendix B for a full description of Pool benefits). Enrollees select a deductible which ranges from $500 to $5,000. Benefits are comprehensive and include inpatient and outpatient physician services, hospital care, surgical benefits, X-ray and laboratory services, home health care, hospice care, serious mental illness benefits, prescription drug coverage, and other services. Enrollees using in-network benefits are responsible for 20% coinsurance costs, up to an annual maximum of $3,000. All enrollees are limited to a lifetime maximum benefit of $1.5 million.

The THIRP is available to state residents who meet one of the following eligibility requirements:

1. Must be a legal resident of Texas for at least 30 days and a U.S. citizen, or a permanent resident of the U.S. for at least three continuous years, and can provide:
    a) Notice of rejection or refusal by one insurer to issue health coverage on the individual due to health reasons: or
    b) A certification from an insurance agent certifying that the agent is unable to obtain coverage substantially similar to Pool coverage due to the individual's health condition; or
    c) An offer by an insurer to issue coverage or a copy of an in-force insurance policy that excludes a medical condition or conditions; or
    d) Either an offer by an insurer to issue a policy or a copy of an in-force policy that provides coverage substantially similar to Pool coverage, but at a premium rate greater than the current THIRP rate; or

e) The individual has been diagnosed with a qualifying medical/health condition (such as cancer, cardiovascular disease, Hodgkin's disease, Cerebral Palsy, etc.)

2. An individual is also eligible for Pool coverage if he/she is a legal resident of Texas who:

   a) has maintained health coverage for the preceding 18 months, with no break in coverage greater than 63 days, provided the most recent coverage was through an employer sponsored plan, church plan or government plan; or

   b) had health coverage under another state's qualified HIPAA health program but lost coverage because the individual moved to Texas; the individual must apply for coverage within 63 days of losing previous coverage; or

   c) the individual is certified as eligible under the Health Coverage Tax Credit Program.

Texas Commercial Health Insurance Market Overview

Before considering options for expanding the THIRP, a discussion of the Texas individual and group health insurance market is necessary to understand the complex insurance environment and the factors that are crucial to maintaining a successful health insurance risk pool. While Texas is generally regarded as having a healthy commercial insurance market with a large number of insurers and HMOs and a variety of insurance products to choose from, certain population segments have difficulty obtaining affordable health insurance. This is particularly true for people with pre-existing health problems and individuals who do not have access to employer-sponsored coverage. Following is a brief overview of the individual and group health coverage markets.

Group Employment-Based Coverage

Like all states, the Texas group employer market is segregated into small and large employer components as follows:

SMALL EMPLOYER: Includes fully-insured plans sponsored by businesses with between two and 50 eligible employees as described in Article 26.02 and Article 26.21, Texas Insurance Code. Also includes small group plans, with some limitations, that have less than two employees or more than 50, if those plans initially were issued as small employer plans but due to enrollment changes either exceeded 50 or

decreased to one during the 2003 calendar year for which you are reporting data. (**Note**: this definition is consistent with the small employer definition included in the federal Health Insurance Portability and Accountability Act.) Also includes school districts that have opted to be treated as a small employer as allowed under Article 26.036, Texas Insurance Code.

LARGE EMPLOYER: Includes fully-insured plans sponsored by businesses with at least 51 eligible employees as described in Article 26.02, Texas Insurance code. It does not include plans which were initially issued to a small employer but due to enrollment changes have 51 or more eligible employees. It also does not include school districts with 51 or more eligible employees that have opted to be treated as a small employer.

Under both state and federal laws designed to assure and protect access to health insurance for small businesses, small employer groups are subject to a variety of regulations and requirements that do not apply to large employer groups. Two key provisions crucial to small employers but not applicable to large employer groups are: 1) guaranteed issue and 2) rate regulation. While these provisions have made insurance easier to obtain and less expensive for some small employer groups, they also have created some market conditions that can negatively affect other small groups.

Guaranteed issue provisions require insurers and HMOs to accept any eligible small employer group that applies for coverage; they cannot reject groups due to the health status of any employee or dependent. Prior to enactment of this provision under HIPAA (1996) and state law (1997), small employer groups often had trouble obtaining coverage from any carrier due to factors including the group's size, the health status of the group, the age of the group members, the type of occupation of the group, or the financial history of the group. While large groups with 50 or more employees are usually not subject to detailed underwriting, insurers and HMOs closely evaluate small employer groups to determine the level of "risk" they represent. Before guaranteed issue, small employer groups that included even one individual with a pre-existing health condition were often declined coverage by most if not all insurers/HMOs. In some cases, the insurers /HMO would accept the group but only if it could decline to cover the individual with the pre-existing condition or exclude from coverage the pre-existing condition.

The smallest groups with 10 or fewer employees (often referred to as "baby groups") faced the greatest challenge in obtaining coverage as most insurers/HMOs generally view them as unprofitable. From an actuarial perspective, group size is an important indicator of the level of risk represented. Insurers desire larger group sizes because they provide more people to share the risk of loss. As group size increases, claims costs are spread across a larger number of people, and the insurer/HMO is more likely to collect enough

premiums to cover the total losses. With “baby groups”, the ability to collect sufficient premiums to cover claims decreases. This factor requires significant premium increases which make insurance unaffordable for many of these smaller groups.

While guaranteed issue made coverage *available* to small employer groups, high premium rates still presented potential barriers to access for small employer groups. To address concerns that rates be maintained at a reasonable level for small employer groups, the Texas Legislature enacted “rate bands” in conjunction with the guaranteed issue requirement. Rate bands limit the extent to which insurers/HMOs can increase rates based on a particular small employer group’s size, occupation type, geographic location, or age of the group members. They also limit the extent to which rates can be increased based on the health status of the group. While the Texas provisions match the federal HIPAA provisions prohibiting insurers/HMOs from declining a group based on health status and prohibiting rate discrimination against any single member of a group based on health status, federal law does not impose the rate band restrictions that are a part of the Texas small employer market requirements. The additional Texas restrictions on rate bands, by restricting rate differences between healthy and unhealthy small employer groups, may increase the cost of coverage for healthier small employer groups, which can result in those groups leaving the market, particularly since their need for insurance may not be as pressing. At the same time, rate bands limit the extent to which rates may be increased for groups with unhealthy members, thus enabling some of these groups to stay in the market.

The Texas rate restriction is a significant departure from earlier market conditions which left rates virtually unregulated within the group market. Over time, the results have been mixed, depending on the characteristics of a specific group. Because premium and loss experience are spread across an insurer’s entire group market, rates are established each year based on the insurer’s total experience for the previous year and anticipated experience for the coming year. Groups that are generally healthy and had few claims in any given year subsidize the losses of groups that had higher claims. Before the rate band requirements, a group with poor claims experience would likely see a significant rate increase from one year to the next. Current law, however, limits that group’s rate increase; the insurer/HMO may have to increase the rates of all groups, including healthy groups, to compensate for the rate band restrictions. After a few years of continued rate increases, some healthy groups may switch to another company in search of a lower rate, or may drop health insurance entirely. At the same time, the process has allowed small employer groups with poor experience to continue their coverage if they are willing to pay the increased premium cost. Absent the rate band restrictions, their premium increases could have been so high that they would have otherwise dropped coverage. However, over an extended period of time, the loss of younger, healthy groups is a serious concern; if these desirable groups continue to leave the small group market,

rates will continue to increase for the remaining small employer groups, causing additional healthy groups to leave the market and making the cost of coverage continue to spiral upward for the remaining small employer groups. Thus, the effects of rate bands must be closely monitored to determine whether further adjustments may be required.

Despite the rate protections, some small groups still face significant challenges finding *affordable* health insurance. Because the rate bands still allow rate variations based on the characteristics described earlier (group size, age, geography, occupation and health status), small groups – and especially baby groups - that are negatively affected by each of these factors will still be subject to insurance rates that are significantly higher than other small groups with different characteristics. Based on previous TDI surveys of the small employer market under the State Planning Grant program, many of these small employers indicated they cannot afford insurance at current levels and would need significant premium subsidies or other assistance in order to purchase coverage. Absent a large decrease in current rates, most uninsured small businesses indicate they are not able to afford coverage.

Large employers are generally maintaining high participation levels in the group insurance market. Because large businesses have more employees to spread the risk and are more stable and generally more profitable, they are better able to afford the cost of insurance and absorb year-to-year increases. While employers have expressed concern about rising health insurance costs, most have continued to provide coverage for their employees. Though large groups do not enjoy the protections of rate bands or guaranteed issue, these provisions are not needed for most of this market segment. Generally, large groups are not subject to the level of underwriting insurers/HMOs apply to small groups. The health status of individual members is usually not a significant factor, although, some of the smallest large groups (groups of 50-100 employees) may be moderately affected if they have high claims or group members with chronic health conditions. As such, insurers rate these groups differently than small groups, and individual group factors do not have as great an impact on large groups.

Group Cooperatives, Coalitions and Association Health Plans

Several other insurance options for small and large employers also exist to make insurance more accessible and affordable for both large and small employers and for non-employer groups. In 1993, the 73rd Texas Legislature authorized small employers to form nonprofit health insurance purchasing alliances, or private purchasing cooperatives. Later legislative action extended this ability to large employers.

Any two or more small or large employers may form a cooperative for the purpose of obtaining health insurance. These cooperatives have specified rights and duties, the most important of which is the power to arrange for health benefit plan coverage for small or large employer groups.

The 78th Regular Legislative Session authorized two additional types of private purchasing cooperatives – health group cooperatives (SB 10) and small employer health coalitions (HB 897). Unlike the original cooperatives, *any person* – other than a health carrier -- may form a health group cooperative. To be eligible to obtain coverage, a health group cooperative must have at least 10 participating employers. A health carrier may associate with a sponsoring entity, such as a chamber of commerce, to assist it in forming a health group cooperative. A carrier can only issue coverage to one health group cooperative in each county, but the service area for that cooperative can cover more than one county, under certain conditions, for an "expanded service area." A health group cooperative has to extend membership to any small employer in its service area, and has the option of accepting a large employer as a member.

Health group cooperatives have features that make them more attractive to carriers. Employers must commit to two years of coverage to join a health group cooperative, except in cases of financial hardship. Carriers are also exempt for two years from certain taxes on premium received for each previously uninsured person covered through a health group cooperative.

HB 897 established another type of private purchasing cooperative -- small employer health coalitions – which are cooperatives composed solely of small employers. An insurer/HMO must treat a small employer health coalition as a single small employer, entitled to guaranteed issuance of coverage as well as small employer rate protections. This type of cooperative is limited in size to 50 eligible employees – the same as a single small employer.

While cooperatives and coalitions are limited to employer groups only, both employer and non-employer groups can obtain coverage under association health plans. In general terms, to qualify for insurance, association groups must have been created for a purpose *other* than obtaining insurance, have a constitution and by-laws, and must be in existence for at least two years before providing an association health plan to members. In theory, because the association plans are generally available to larger groups of people, the larger membership may result in lower insurance rates, particularly for small employer groups that participate or for association members that would otherwise purchase an individual insurance plan. For employer associations, Texas law requires that the employees and dependents of any small employers that are members of the association be entitled to guaranteed issuance of coverage. The large employer members of an employer association are not entitled to guaranteed issuance, but do enjoy other provisions available to large employers

such as guaranteed renewability and some rating protections (but to a lesser extent than small employers).

A non-employer association ("member association") may purchase any policy that has been approved for sale as a group product. However, unless the association is a "bona fide association" (a defined term under state and federal law), the insurer may underwrite each individual member and may decline to offer coverage or issue coverage excluding a particular medical condition, based on the health status of the member. Members of a bona fide association are eligible for coverage without regard to health status.

Most of the non-employer associations in Texas are non-bona fide associations. Though there is no single reason that discourages the creation of bona fide associations, a common problem is the tendency of those association members who can obtain better rates elsewhere, to leave the association plan and purchase coverage on their own, which leads to higher premiums for the remaining members.

Finally, it is important to recognize that the business environment in which large businesses operate is often very different than that of small employers. Large employers have reported a strong incentive to offer health insurance in order to attract and retain good employees, as they compete against other large businesses that commonly offer insurance coverage. Small employers are often in businesses that attract and compete with other small businesses and, as a group, are less likely to find insurance benefits necessary in order to attract employees. For example, large manufacturing companies nearly always provide health insurance, and are better suited financially to do so. Small doctor offices, retail businesses, or auto repair shops with less than 10 employees, on the other hand, are competing with other similar businesses; they do not have to offer insurance to attract employees because most of their competitors do not offer coverage. Consideration of these and other business factors, as well as insurance market conditions, is necessary to fully understand how one change in the market structure may not have the expected effect, or could even have unintended negative consequences, depending on the many variables that influence an employer's decision to offer health insurance.

Individual Coverage

For those Texans who do not have access to a group plan, the individual insurance market remains a viable option for many. Though not as large as the group market, more than a million people were insured under individual plans in 2003. This market is subject to regulations and requirements that vary significantly from those that govern group health insurance plans. Three particular provisions that are important in the context of the Texas Health Insurance Risk Pool are: 1) all individual health applicants are subject to health

underwriting requirements and will likely be declined or offered only reduced or restricted coverage if a pre-existing health problem exists; 2) TDI does not prescribe rates for individual insureds, which are subject to review primarily for reasonableness in relation to the premium; and 3) the Pool is generally the only alternative for individual applicants who are denied coverage.

As discussed earlier, health insurance underwriting allows insurers/HMOs to evaluate the risk a particular insured poses to the company. Insurers/HMOs often decline to cover people with current health problems or a history of previous serious illness since they are statistically more likely than healthy people to incur claims. Though underwriting criteria vary by company, people with chronic illnesses or injuries are almost always denied coverage. People with less serious illnesses or health problems that occurred five or more years ago may be able to obtain coverage at a higher rate, or may find a plan that covers everything except care related to the previous illness or injury. If coverage is not available or is restricted, the only remaining insurance option is the Pool.

Adequacy of Coverage – Individual and Group Plans

Finally, in all of these markets discussed above (employment-based, association and individual), some plans offer limited benefits that may be inadequate coverage for someone with a chronic health condition or serious illness. Most people with group insurance plans have comprehensive benefits that provide adequate coverage for most any health problems. However, as the cost of group coverage has increased, more employers each year have chosen "limited benefit plans" that offer restricted coverage that may not provide adequate protection in the event of a catastrophic illness or injury. For example, some plans may limit the annual benefit to a low amount, such as $5,000 or even less, or may cover hospitalization costs only up to $5,000. For someone with a major illness such as cancer or a heart attack, these limits would clearly not be adequate.

TDI does not know how many group policyholders are covered by the limited benefit plans, but we do know they are becoming more popular each year. While these plans do provide some limited coverage and are preferable to an individual going entirely without insurance, they will not cover many medical expenses. Most importantly, if a person is covered under one of these plans through an employer, *he/she is not eligible for coverage under the Pool.* Under the eligibility requirements and restrictions of the Pool, an individual is not eligible for the Pool if they have access to employment-based coverage of any kind. This is true *even if the person declines the employer's plan.*

The similar restriction applies to individuals who purchase an individual limited benefit policy. The Pool statute allows such an individual to join the Pool, but requires the individual to terminate the other individual policy. There have been cases where a person would like to keep the reduced benefit policy in addition to

coverage under the Pool, but the Pool statute does not allow "double coverage. For example, an individual with a disease that is under control, or is in remission, may not expect to experience any large medical costs, but still would like some coverage for routine medical costs. For that individual, a reduced benefit plan might be attractive, and may be their only option in the commercial market due to the history of previous illness. However, the person may also want the assurance of a catastrophic plan in the event the illness recurs. Since the Pool rates are much lower for a high deductible plan, an individual might find it economically feasible to purchase a limited benefit plan to cover routine expenses, and the high-deductible benefit plan from the Pool to cover any catastrophic expenses. This option, however, is not currently available.

While the intent of the Pool's restriction is to make certain the Pool does not compete with the commercial market but is truly an "insurer of last resort," one effect is to restrict access for some people who have some limited health insurance, but need additional catastrophic coverage. The challenge of revising this restriction is determining which individuals are truly "underinsured" since no standard exists for measuring insurance adequacy. Individuals who purchase these plans but who need more comprehensive coverage offered through the Pool and who would otherwise qualify for the Pool, could be accepted with the caveat that the Pool benefits would only apply after other insurance benefits are exhausted.

Federal Considerations

HIPAA Limitations and Requirements

Throughout this report, several references have been made to the federal Health Insurance Portability and Accountability Act (HIPAA), enacted by Congress in 1996 to improve access and affordability of health insurance. As discussed in the section above outlining group market conditions, the HIPAA requirements affecting small employer groups were intended to guarantee that all small employers can obtain coverage. The law also specifically prohibits discrimination against employees (and their dependents) with health problems, and requires that these individuals be treated the same as any other employee for purposes of insurance benefits. While these new protections generally work to the benefit of small employers, they also restrict states from allowing any market flexibility alternative that conflicts with the federal provisions, even if it might prove more advantageous for the small employer group market as a whole. As such, suggestions that would in some way treat certain group members differently than others on the basis of their health status clearly violate HIPAA provisions. A more extensive discussion of these provisions and others related to Pool expansion options begins on page 16.

Federal Funding Opportunities

Though risk pools have historically received only state and local funds, two separate federal provisions recently provided limited federal funding opportunities: 1) the Trade Act of 2002, and 2) the federal Health Care Tax Credit program. Following is a brief description of the two programs.

Trade Act of 2002 – Operational Grant Program

The Trade Adjustment Assistance Reform Act of 2002 (Trade Act of 2002) included provisions that provide start-up assistance for new state health insurance risk pools, and operational funding of existing qualified pools. Congress appropriated a total of $20 million for the creation of a new, qualified risk pool in 2003, and $40 million in both FY 2003 and FY 2004 for qualified existing pools. To qualify for seed funds to establish a new pool, the state must not have created a *qualified* high risk pool as of August 6, 2002.

To be eligible for any funds, the risk pool must meet certain "qualification" provisions:

- The Pool must provide coverage to all HIPAA eligible individuals, and the coverage must not impose any preexisting condition exclusion on those individuals;

- The Pool premium rates must be capped at no higher than 150 percent of the applicable standard risk rates for health insurance in the state; and

- The Pool must offer a choice of two or more coverage options.

Congress provided that the grants were to be divided among the eligible risk pools according to a formula that is based on the number of uninsured citizens in a state. Under rules adopted by the Centers for Medicare and Medicaid Services (CMS), states were allowed to apply for operating grants for two years out of a three-year period. The first operational grants were awarded in December 2003 to 16 eligible state risk pools.

Texas was not eligible to apply for either of the grant programs (start-up grant or operational grant) because the THIRP does not meet the premium cap requirements. Under Texas law, premiums in the pool may not exceed 200 percent of the standard risk rate. In order to qualify for the federal funds, the cap would have to be limited to 150 percent. The 78th Texas Legislature considered but did not pass a provision to cap premiums at 150 percent (SB 467**).** Though we do not have an exact figure of the federal funds that Texas could have received, the state has one of the highest numbers of uninsured residents in the

country and would have, therefore, been eligible for one of the larger grants. The estimated approximate share that Texas would have qualified for in calendar year 2003 was $13 million.

In addition to the federal funds that the THIRP could have received under the Trade Act of 2002, if the pool's premium cap were lowered to 150 percent, the reduction in premium would have also made the coverage affordable for more Texans. However, it is unlikely that the grant funds would be large enough to cover the difference in the loss of funds to the pool that would result from the lower premium rates; larger or expanded assessments on insurers and HMOs would ultimately have to compensate for the difference (see page 4 for a description of pool funding and assessment provisions).

Although Congress has not yet enacted legislation to extend the Operational Grant Program into 2004-2005, legislation to do this passed the Senate in 2004 and is expected to be re-introduced early this year. If Congress reauthorizes the provisions, additional funds would be available to Texas. However, unless Congress eliminates or raises the 150 percent cap, Texas still would not qualify for the additional funds unless the Legislature lowers the Pool premium cap.

Trade Act of 2002 - Health Coverage Tax Credit Program

The Trade Adjustment Assistance Reform Act also included provisions to help displaced workers obtain health coverage. The Act provides a federal income tax credit to cover health insurance costs for certain displaced workers affected by foreign trade, and retirees receiving payments from the Pension Benefit Guarantee Corporation (PBGC). Eligible people can receive a tax credit equal to 65 percent of the premium paid by the individual and family members for qualified health insurance coverage.

Eligible individuals automatically qualify to receive tax credit assistance for three types of coverage:

1) COBRA coverage – any continuation coverage that is available to the individual under the federal COBRA act;
2) Spousal coverage – group coverage available to the eligible individual through a spouse's employment, if the employer contributes less than 50 percent of the total cost of coverage for the individual, spouse, and dependents; and
3) Individual market coverage – coverage in which the individual was enrolled for at least 30 days before separating from the job that made him/her eligible for assistance.

In addition, the Act provides seven specific types of coverage options that states can choose to serve as their Health Care Tax Credit (HCTC) acceptance

program. One of the seven options is coverage through a state high risk pool. Texas elected to use the THIRP as a qualified option for the HCTC program. As such, individuals who are eligible for the tax credit but cannot obtain coverage except through the THIRP can receive the credit to assist with Pool premium payments. Individuals actually receive their credit in one of two ways: monthly as their premiums are due as an advanceable tax credit, or as a refund under their federal tax returns.

In calendar year 2004, 16 members enrolled in the Pool under the Tax Credit.

Texas Health Insurance Risk Pool Expansion Options

Since the Pool was established in 1997, enrollment has grown from 2,946 in calendar year 1998 to 24,675 in 2003. As of December, 2004, enrollment had reached 26,574 Texans, making the Pool the second largest in the country. The management of the Pool benefits, premiums, eligibility criteria of members, and assessments of insurers and HMOs requires maintaining a delicate balance of competing needs in order to ensure the continued viability of the Pool. Though premium rates are high, premiums of the THIRP members do not cover their corresponding claims. High premiums are a significant concern as many eligible Texans cannot afford the cost. Though a reduction in premium rates would certainly allow more people to afford the THIRP coverage, other sources would have to compensate for the reduced funding, or coverage would have to be altered to provide fewer benefits. Each of these alternatives is complex, however, and must be carefully considered.

Another option for expanding coverage is to open enrollment to a larger population, particularly to some small employer groups that may pay higher than average prices due to the health problems of a group member. This option in particular has received considerable attention in the course of our study and is discussed at length in this report. However, this option is also complicated and must be evaluated for its effect not only on the Pool, but the entire small employer group market. The remainder of this report discusses these options and several others, which are briefly summarized below:

- A. Small Employer Buy-In Options - allow certain small employer groups to enroll as a group, or to enroll only members that have a health condition that would qualify for individual coverage;

- B. Risk Pool Eligibility Changes - loosen the eligibility requirements for individual members, allowing certain people who may be excluded due to relatively technical requirements to obtain coverage in the Pool;

- C. Federal Funding Opportunities - evaluate the Pool provisions that disqualify Texas from receiving certain federal funds, and the impact federal funds would have on Pool enrollment and participation;

- D. Assessment Methodology Change - consider expanding the assessment base to include self-funded employer groups, which could result in lower premium costs and allow more Texans to participate in the THIRP

- E. Reductions in Premium Costs to Improve Affordability - consider options that could reduce the cost of coverage under the Pool, thus allowing more Texans who are eligible but cannot afford coverage to enroll; and

A. Small Employer Buy-In Options

The Texas Health Insurance Risk Pool is currently available only to individuals who meet the eligibility requirements and their dependent family members (spouse and children). Coverage of employer groups is not an option. However, participation in the Pool has been suggested as an alternative for some small employers who are paying high insurance rates due to one enrollee's health problems that increase the cost for the entire group. One option would be to open the THIRP to entire small groups, while another would be to allow only the group member with a qualifying health problem to enroll. These options appear to be fairly simple, but are quite complex and involve both state and federal statutory challenges.

Several important factors are critical to an informed discussion of this concept. First, group health insurance rates and underwriting guidelines are subject only to limited TDI approval or control, and vary significantly from one carrier to another. While the rates and guidelines cannot be unfairly discriminatory and generally must be applied in a uniform manner within a company, each insurer/HMO uses their own underwriting guidelines to determine which medical conditions constitute an increased risk, and the appropriate rate decision that applies to that risk. For example, one insurer may decide that a past history of cancer more than five years ago with no recurrence poses a relatively low risk while another carrier may determine that it poses a significant risk. Carriers' rates reflect the varying analyses of degrees of risk. A group that includes a member with a past history of cancer may find that one insurer offers them a "standard" rate, while another insurer may offer a "substandard" rate that is considerably higher due to a perception of the increased risk of recurring cancer.

Also, insurers and HMOs apply different underwriting criteria to small groups than to large employer groups. Whereas large employer groups generally are not

subject to individual underwriting of each group member, small employer groups are routinely underwritten. While the premium rates for a large employer group are not usually affected by one or even several unhealthy group members, one unhealthy group member can significantly affect the rates for a small employer group, even if the health problem occurred several years earlier.

Though TDI does not prescribe group health insurance rates, state law does impose some restrictions in the form of "rate bands" on small employer group rates, and also regulates the extent to which insurers/HMOs can increase rates due to health status. However, these restrictions have conflicting results; while they may limit the extent to which groups with unhealthy members are charged higher rates, they also may result in higher rates for the healthiest groups. Rate bands may discourage healthy groups from purchasing coverage and, over time, may lead to higher rates for all insureds as fewer "healthy" groups choose to purchase coverage.

Small employers in particular can face steep health insurance premium rate increases if a member of the group (an employee or a dependent) has a pre-existing health problem, or if they develop such a condition after the inception of coverage. While large employers have a larger group over which to spread the risk and are not generally affected by the health condition of individual group members, small employers are subject to a higher level of medical underwriting and can be significantly affected by even one member's health condition. Although state law imposes some limitations on the extent to which small employer groups can be penalized based on the health status of a member, the rate difference between a "healthy" group and an "unhealthy" group can be significant. In some cases, it is possible that the group rate is actually more expensive than the rate that would be charged if the same members of the group were each enrolled in the Pool on an individual basis. While such occasions are likely rare, they raise questions about the effectiveness of expanding the THIRP to allow small groups to enroll.

As discussed previously, the Health Insurance Portability and Accountability Act (HIPAA) includes several provisions that protect employees who have preexisting medical conditions or who might suffer discrimination in health coverage based on a factor related to the individual's health. The Act prohibits employer-sponsored group health plans, insurance companies and health maintenance organizations from excluding or providing different benefits for any individual based on "health status factors" which includes an individual's health status, physical or mental health condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. The plans also may not charge a higher premium for any **individual** based on a health-status related factor. However, the law does not prohibit an insurer from charging a higher premium for the entire **group** if only one individual has a preexisting health condition.

HIPAA also provides considerable privacy protections for employees that prohibit employers from receiving or accessing an employee's personal health information. Since an employer would need to identify an "unhealthy" individual in order to consider enrolling that employee in the Pool, the employer would need information about employees' health status. While in some cases an employer may already know private information due to voluntary disclosure by the employee, this is certainly not true in all cases. Creating a program that would in any way encourage or require the provision of private health information would require careful crafting to avoid violating the privacy protections of HIPAA.

These provisions raise significant legal questions concerning whether an unhealthy group member could be excluded from the group health plan and separately enrolled in the THIRP as some have suggested. Clearly it would be a violation of the HIPAA guaranteed access provisions if an employee was specifically excluded from the group plan, even if the employer paid the full cost of enrolling the excluded employee in the THIRP. Even if the decision not to enroll in the group plan is entirely voluntary on the part of the enrollee, the Department of Labor may find that the employer's "suggestion" or "offer" to enroll the employee in the THIRP violates the intent of HIPAA by placing undo pressure on the employee to "voluntarily" refrain from enrolling in the group plan. A change in federal law would be necessary to remove this barrier. If Texas enacts a system that is non-compliant with HIPAA, Texas would be treated as a "federal fallback" state and the federal government, not the state of Texas, would regulate the Texas health insurance market.

A further challenge for any proposal that would create a dual system for "healthy" employees" and "unhealthy employees" is the fact that THIRP benefits may not be comparable to benefits offered under a typical group insurance plan. Despite these and other challenges and in order to adequately respond to the provisions of SB 467, TDI contracted with Milliman (the actuarial firm for the THIRP) to conduct a study of options for enrolling small groups or allowing individual members of small groups to enroll in the pool. The Milliman analysis was conducted and paid for as part of a federal State Planning Grant awarded to TDI to study uninsured Texans.

Evaluation of Employer Buy-In Options – Milliman Study

In 2001, Texas received a federal State Planning Grant for the purpose of studying the problem of the uninsured, and developing options for expanding health coverage in Texas. As part of that study, TDI contracted with Milliman to evaluate various options for allowing certain individuals and groups to "buy in" to the THIRP. Milliman provided a summary of its findings in January 2003, which is included in its entirety in Appendix A of this report. Additional analysis from a September 2004 supplemental report is also included.

The Milliman study evaluated scenarios that would allow both entire small "baby groups" to enroll in the Pool, and those that would allow only unhealthy group members to enroll in the Pool, leaving the healthy members together and covered under a small employer plan in the commercial market. Milliman considered the options using a variety of actuarial assumptions, and considered how other market changes (including some which would require legislation) might affect the outcome. Though it is impractical to briefly summarize the many technical issues addressed by Milliman's actuarial evaluation, Milliman concluded that none of these options would provide significant pricing relief for small employers. Milliman pointed out that rate band restrictions applicable to small groups generally would keep small group rates lower than rates available in the Pool. This could change somewhat if a separate, lower rate structure were implemented for groups enrolled in the Pool. In a few limited cases, Milliman provided examples of where a group might benefit from either a group buy-in or an individual buy-in, but those results depend on very specific circumstances and conditions that do not apply across the board. They also point out that this option may result in other unintended consequences, such as an increase in rates for the commercial small employer market.

Finally, it must be emphasized again that federal HIPAA provisions prohibit insurance actions that in any way discriminate against employees with health problems. Even if moving sick employees out of a group and into the Pool was determined to be a viable alternative from an actuarial perspective, it would not be permissible under current federal law and would result in federal preemption and control of the Texas group insurance market.

B. Risk Pool Eligibility Changes

Another option for allowing more individuals to access the THIRP is to change the eligibility requirements that currently restrict certain individuals from enrolling. Under the current requirements for THIRP enrollment, individuals generally must be state residents, and: 1) qualified under HIPAA, which requires exhaustion of COBRA continuation; 2) have a medical condition or medical history that makes insurance unavailable; 3) able to obtain only an individual insurance plan with rates that are higher than those in the Pool; 4) qualify for coverage under the Health Coverage Tax Credit Program; or 5) have lost coverage under another state's qualified HIPAA program upon moving to Texas. It has been suggested that these requirements may, in some cases, be too strict, in effect restricting people from enrolling due to relatively minor technicalities. Following is a discussion of specific adjustment to enrollment restrictions that could make Pool coverage accessible to more Texans.

1) Allow individuals who are eligible for continued benefits under COBRA (Congressional Omnibus Budget Reconciliation Act) to instead enroll in the Pool if coverage in the Pool is more affordable or offers better coverage.

Under the federal COBRA continuation provisions, individuals who are covered under a group employment-based health plan but lose coverage due to job loss or a change in family status (such as divorce or death of a spouse), have the right to continue coverage under the group health plan for a period of 18 to 36 months. The individual must decide whether to enroll in the continued coverage within 60 days of losing coverage (or the date of COBRA notice, if later), and is required to pay the full cost of the coverage plus a two percent administrative fee. Coverage is available to both the employee and other affected family members at the time they need to make that decision; however, the full premium cost must be paid for each covered insured.

In many cases, the cost of continuing COBRA benefits is unaffordable at the time the election has to be made, particularly for employees who lose their job and have no other employment. Once an individual declines COBRA coverage, he/she cannot go back and later elect coverage once the 60 day eligibility period has passed.

The THIRP eligibility provisions restrict an individual from enrolling if the individual is covered by or declined COBRA coverage for the period that COBRA coverage is or could have been continued. Though there is no data on the number of people affected by this provision, TDI has received complaints about this restriction from Texans who were unable to enroll in the Pool.

For example, consider the case of a 40 year-old woman with two children, whose husband dies suddenly. Until the death of the husband, the family was insured under the husband's health plan available through his employer. Upon his death, the family is notified that they will lose their group health benefits, but can enroll under the COBRA provision. However, they will be required to pay the full premium cost of the plan, which is approximately $1,100 a month.

At the time of the husband's death, the wife did not have the $1,100 required to pay the first month's premium. Three months later (or approximately 90 days), she receives life insurance proceeds and is now able to pay the COBRA premium. However, the 60 day enrollment opportunity has passed, and she is no longer eligible for coverage.

The wife then applies for an individual health insurance plan. However, because she received treatment for skin cancer two years earlier, she is "uninsurable" and cannot find an insurer who will cover her. The only alternative for her is the THIRP. Unfortunately, because she refused COBRA coverage available to her upon her husband's death, she finds out that she is not eligible to enroll in the Pool for 18 months (from the date she lost the employer coverage). Thus,

despite her ability and willingness to pay for private insurance, she cannot obtain any coverage.

This problem could be addressed by allowing individuals to choose the THIRP coverage, without having to first exhaust COBRA coverage.

2) Allow individuals with insurance that provides limited coverage to enroll in the Pool.

Earlier in this report, we describe the effect of individual "limited benefit plans" on individuals who need more comprehensive coverage due to a chronic health problem (see page 11). Because the THIRP does not allow an individual to retain these policies if the THIRP issues coverage, some individuals, who cannot afford the THIRP lower deductible plans, are forced to remain on the limited benefit plans only. If these individuals are allowed to retain these limited individual plans to cover more routine, less costly medical care, the individual could purchase a higher deductible THIRP policy at a more affordable rate and insure for the possibility of more catastrophic medical problems.

C. Federal Funding Opportunities

Under the Trade Adjustment Assistance Reform Act of 2002, federal grants were available to certain eligible risk pools to cover expenses in 2002 and 2003. Texas was not eligible for the funds due to the premium cap in excess of 150 percent of the standard rate (see page 13 for more discussion). Congress has expressed an interest in appropriating additional grant funds for 2004 and 2005. Under the THIRP existing statutory premium cap of 200 percent, the Pool would not qualify for the funds if they are limited by the same condition. Assuming Congress does not increase the premium cap limitation, or remove it entirely, Texas will need to enact legislation to limit the premium cap to 150 percent of the standard rate in order to qualify for future funds.

D. Assessment Methodology Changes

As described in the Pool overview section, Texas law provides that Pool losses in excess of premiums collected be funded with assessments on Texas insurers and HMOs. Assessments are determined based on an insurer's/HMO's percentage share of the gross premiums collected for health insurance in Texas. However, as with all types of insurer assessments, they apply only to fully-insured plans and not to self-funded plans used frequently by larger employers. In Texas, estimates of the self-funded market range from 40 to 60 percent of all covered employees. These employment-based plans are, in effect, exempt from supporting the Pool losses. Because large employers represent the

overwhelming majority of self-funded plans, small employers end up paying a disproportionate share of the assessment costs through the insurance premiums they pay to carriers/HMOs.

One approach to address this inequity is to base the Pool's assessment on the number of lives each carrier covers – in both individual and group plans - rather than on the premium volume. In addition, carriers that provide stop loss and excess loss type coverage would be subject to assessment based on the number of employees in a group the carrier insures or reinsures. Since many self-funded large employers purchase stop-loss and excess loss coverage to limit their risk, changing the methodology would allow a more equitable distribution of costs across all employers, including both self-funded and fully-insured.

Changing the assessment methodology would be particularly important if the Legislature reduced the Pool premium cap to 150% in order to qualify for federal grant funds. Since the reduction in the maximum premium rate would bring in reduced premium funds and would likely have the effect of increasing carrier assessments, changing the methodology to a "covered lives approach" would mitigate the cost increase.

E. Reductions in Premium Costs to Improve Affordability

One of the most critical factors affecting the enrollment in risk pool programs is the affordability of premiums. Though cost varies significantly based on each state's pool program criteria and funding mechanisms, most state pool premium rates are higher than standard commercial rates. In Texas rates vary considerably based on the age and residence of an individual, whether they use tobacco products, and the deductible plan selected. The average monthly premium paid in 2004 was $478, but can be as high as $1,866 a month for the lowest deductible plan ($500) covering a male age 60-64, with a history of tobacco use. Though rates are lower for non-tobacco users and for younger people, the rates are always considerably higher than the standard commercial rates. Cost of the pool is the most frequent reason why eligible, uninsured Texans do not enroll, or cancel existing THIRP coverage. A reduction in premiums is commonly recognized as one way of increasing enrollment in the Pool. Three alternatives for lowering premium costs are discussed below.

1) Reduce benefits

The THIRP offers comprehensive health care coverage, comparable to commercial individual health plan coverage. At the time the Pool was created, extensive discussion was held to determine what benefits were necessary for the population that would be insured. Since the Pool enrollees are unhealthy and are likely to need medical care on a regular basis, the consensus was that

coverage should be comprehensive and should broadly cover the types of care that the enrollees would require.

Although a reduction in benefits would result in lower premiums, the change would also likely lead to higher out-of-pocket expenses for the Pool enrollees. If the Pool benefits are reduced to the point that they become of questionable value to the insureds, the end result could actually be a reduction in the number of enrollees rather than an increase.

2) Increase Cost Sharing Provisions

Another option for lowering premium costs is to increase the deductible and coinsurance requirements under the plan. The plan currently offers four annual deductible options: $500 (Plan I, selected by 12 percent of enrollees); $1,000 (Plan II, 25 percent of enrollees); $2,500 (Plan III, 43 percent of enrollees); and $5,000 (Plan IV, 20 percent of enrollees). The insured also must pay coinsurance costs of 20 percent of the cost of services for in-network benefits, up to a maximum of $3000 a year. There is no limit on coinsurance costs for out of network benefits. Lifetime benefits are capped at $1.5 million.

The Pool originally offered deductibles up to $2,500. In July of 2002, the THIRP Board opted to add a $5,000 deductible. A higher deductible reduces premium costs significantly. For example, the cost for a 30 year old, non-tobacco user male under Plan I with a $500 deductible is $389 a month in Area 1, compared to $154 under Plan IV with a $5,000 deductible. At least four other state risk pools offer up to a $10,000 deductible plan, and two other plans provide a deductible up to $7,500. The Pool Board has considered adding a deductible of up to $10,000, but has opted at this time not to raise the deductible until additional experience data is available for the $5,000 deductible plan. The Board is likely to consider a higher deductible option in the near future.

3) Provide Premium Subsidies or Discounts for Low-Income Individuals

One additional mechanism for expanding Pool access is to implement a premium subsidy or premium discount program for low-income Texans who qualify for Pool coverage but have incomes below a certain threshold. At least nine states have developed premium subsidy or discount programs to assist low-income individuals who meet the health eligibility requirements for the pool but cannot afford the premiums. Following is a brief description of several programs based on information provided in the annual publication, *"Comprehensive Health Insurance for High-Risk Individuals – A State by State Analysis",* 2004/2005 Edition*:*

Colorado Premium Discount Plan

The Colorado risk pool offers a 20 percent premium discount to enrollees whose annual household incomes are less than $36,000 a year. The program has been in effect since September, 2001.

Connecticut Special Health Care Plan

The Connecticut high risk pool (Connecticut Health Reinsurance Association) established in 1990 a subsidy/reduced premium plan that is available to enrollees up to 200 percent of the federal poverty level. The plan reduces costs to these members using three components: 1) Health care providers in the state accept reduced benefit payments when treating qualified low income participants. The reduction in provider payments enables the pool to reduce premiums for these low income members. 2) Providers agree to accept as "payment in full" the payment made by the Pool. They do not "balance bill" low income participants for any costs above what the Pool pays, thus saving the low income participants additional health care expenses. 3) The deductible for low income participants is reduced from $500 to $200 for an individual, and from $1,000 to $400 for family coverage. The reduction is in effect funded through an increase in assessments that cover overall losses above premium income.

Oregon's Family Health Insurance Assistance Program

Oregon residents with family incomes up to 185 percent of poverty level are eligible for premium subsidy assistance. The Family Health Insurance Assistance Program (FHIAP) pays a portion of the premium cost: 95, 90, 70, or 50 percent, depending on an applicant's average gross monthly income. The applicant must be uninsured for six months prior to application.

Washington State Health Insurance Pool (WSHIP)

Under legislation enacted in 2000, the WSHIP can offer discounts totaling $200,000 for the current biennium. Discounts are offered as follows, until funds are exhausted: for 50 to 64 year olds, a 30 percent discount if the household income is less than 250 percent of poverty level and a 15 percent discount if the income is 250 to 301 percent of poverty level. In addition, a five percent discount is offered to any person who has been enrolled in the pool for 36 months or more.

Wisconsin Health Insurance Risk Sharing Plan (HIRSP)

In 1985, Wisconsin created the first subsidy program to assist low income people enrolling in the state's high-risk pool. Subsidies are provided in the form of premium cost reductions based on the enrollees' annual household incomes. Approximately 23% of the pool enrollees with incomes below $25,000, qualified

for the premium reduction in 2003. The cost of the premium reductions is funded by periodic assessments of health insurers and adjustments to provider payments. The total cost of reductions for 2003 was $4.9 million.

Montana Comprehensive Health Association

In 2001, the Montana Legislature authorized subsidies for low income persons who purchase coverage from the Montana Comprehensive Health Association. The subsidies are 65 percent of premium during the pre-existing waiting period (four months) and decrease to 55 percent after the waiting period is completed. Federal money was used to help fund the subsidy program, with additional funds appropriated by the state.

APPENDIX A

Following is the entire text of the Milliman USA report addressing THIRP buy-in options, submitted by Milliman USA in January 2003 and September 2004:

January 15, 2003 – Analysis of Small Employer Buy-In to the Texas Health Insurance Risk Pool by Milliman USA – Report to the Texas Department of Insurance

"…. There is some interest in exploring the possibility of small employers purchasing coverage for their employees in the Texas Health Insurance Risk Pool (THIRP or the Pool). This letter explores that option and underlying issues. We completed this analysis as part of the State Planning Grant Project. Please note that we are also the actuaries for the Texas Health Insurance Risk Pool.

In this letter, we consider two different general designs for a buy-in. In both instances, we focus our examples on the smallest group sizes, such as under 5 or 10 employees. For the first buy-in design, we assume an employer can secure health insurance for one or more of his higher risk employees in the Pool while purchasing small employer coverage through a carrier for his healthier employees. We refer to this buy-in design as the "Individual Buy-In".

The second way the buy-in program may be designed is with a small employer allowed to buy coverage for the entire group through the Pool. We refer to this design as the "Group Buy-In". Both of these designs are discussed in detail in this letter.

Results

Based on our analysis, we conclude that:

- An Individual Buy-In would allow employers with uninsurable risks in the group to secure health insurance at a lower cost;
- A Group Buy-In would allow these employers to secure health insurance at a lower cost only if THIRP rates are reduced;
- A number of issues associated with an Individual Buy-In may make it infeasible;
- If the increased assessments necessary from a Group Buy-In are supported only by the small employer market, the results are similar to tightening the small group rating restrictions;

- There may be some advantages to a Group Buy-In approach if it is part of a broader strategy and set of changes associated with baby groups (below 5 or 10 lives).

We start our discussion by addressing the potential impact on particular employers, and then discuss the impact on the small employer health insurance market in the State. We address the issues associated with an Individual Buy-In and suggest a scenario with a Group Buy-In approach for further consideration.

Employer Perspective and Relative Rates

First we consider some specific situations where an employer could lower his premium costs if he is allowed to buy into the Pool. We start with some assumptions with respect to rate relativities among various markets. The development and detailed assumptions are contained in the attached exhibit, with the results below:

Rates per Enrollee per Month

$200 – Individual Health Rate – New Business, Preferred
$192 – Small Group < 10 Lives, Preferred
$320 – Small Group < 10 Lives, Maximum Rate
$400 – THIRP Individual Rate

Individual Buy-In

As an example of how the Individual Buy-In might work, assume that an employer has 4 employees who need health insurance coverage. One of these individuals is considered a high risk while the others are healthy. Because of the one high-risk individual, small employer carriers are charging the maximum rate for all four employees, or 4 x $320 = $1280.

Alternatively, if the employer is allowed to cover the one high-risk individual in the Pool, the small employer carrier might charge the preferred rate for the remaining three employees. Therefore, the total rate would be 3 x $192 + 1 x $400 = $976, resulting in a 23.8% discount from the rate in the small employer market.

For a similar situation with a 10 life group, the employer may see a 33.5% discount. This assumes he would be charged 10 x $320 = $3200 per month in the small group market and $2128 per month (9 x $192 + 1 x $400) with the Individual Buy-In.

Group Buy-In

Again using the relative premium rates described above, we consider a program that allows an employer to purchase insurance for its entire group through the Pool. The impact of a Group Buy-In option on an employer would depend on the level of the Pool premium rates. If small employers are simply allowed to buy into the Pool at the currently legislated Pool rates, they are not likely to find lower premiums in the Pool than they can get in the small group health insurance market. This is because the small group rating restrictions limit rates in the market more than the rate cap requirement limits rates in the risk pool.

Note that the maximum rate above for a group size of less than 10 is $320 per enrollee per month. This rate is less than the Pool rate of $400 per enrollee per month. Texas small employer legislation limits the maximum rate to 167% of the minimum rate for small employers. On the other hand, current legislation requires the Pool rates to be ultimately set at 200% of the individual health market rate.

The Pool rates for groups could, however, be set at some lower level, such as 150% of the average individual health market rate, or $300 in our example. In this case, the employers described earlier could secure rates that are 6.25% lower than their current rates in the small employer market ($300 per enrollee rather than $320).

These examples are theoretical, but are intended to show how an employer may gain an advantage through using the Pool mechanism. The examples assume that pricing in the market is efficient and consistent across carriers and rating cohorts. This will not always be the case; therefore, the rate relativities will not always be consistent with those listed above and the results for a specific employer group may differ from those illustrated.

In the examples, we have assumed that the Pool rates are set at 200% of individual health rates. Currently, they are equal to 180% of individual rates. Current legislation requires them to ultimately move to 200%; however, there is also a push towards lowering the cap to 150%.

Market Impact With Assessments on Small Employer Premiums

The examples above illustrate that a buy-in program could be advantageous to small employers who have enrollees with high cost health conditions. It could allow such employers to secure lower rates through the Pool mechanism.

The buy-in program would then result in increased enrollment in the Pool. Because the Pool premiums are not self-supporting, this would lead to increased assessments. Note that small employer premiums are currently excluded from the Pool assessment base. It would be reasonable to assume that if a buy-in

were implemented, small employer premiums would be brought into the assessment base or there would be a separate assessment on small employer premiums.

If all of the increase in Pool assessments are allocated to small employer carriers, the expected results would be 1) enrollment in the Pool would increase, 2) Pool assessments would increase, 3) small group health insurers in the State would be charged for the increased assessments, and 4) general small group premium levels would increase (to cover the assessments.) In addition, we would expect that the small employer reinsurance pool would cease to exist.

In general, the impact would be very similar to the impact of implementing more restrictive rating requirements in the small group market. If, for example, the allowable rate bands are limited to +/-10% rather than the current +/-25%, you may see the following results:

- Some employers with high risk enrollees will be able to purchase small employer coverage at a lower cost than they can currently;

- The additional risks will be spread across the other insureds, resulting in higher general rate levels in the small employer market.

If these are the desired results, the more straightforward approach may be to change the rate bands rather than designing and administering a buy-in program to the Pool. Additional considerations related to an Individual or Group Buy-In are discussed separately below.

Critical Issues Associated with Individual Buy-In

There are a number of issues related to an individual buy-in that may make it infeasible. First, while the intention of such a program would be to lower the number of uninsureds, we would expect enrollment in an individual buy-in to be quite low.

It is likely that only a small fraction of employers could gain a price reduction by insuring various individuals in the Pool, and the price reduction may not be significant enough to change their decisions about offering health insurance. In addition, we would not expect many small employers to even explore the option. As noted in the surveys of small employers, they already find the purchasing of health insurance to be a complex undertaking. They find it difficult to solicit and compare quotes of multiple carriers. In order for them to explore whether it is worthwhile to also use the Pool, they would need to solicit multiple quotes from each carrier (e.g., with and without a particular high risk individual). Even if carriers were willing and legally allowed to do this, it would be difficult for employers to evaluate the resulting rate quotes.

There are also privacy issues to consider. If employers are allowed to make decisions about which enrollees to place in the pool, they are encouraged to seek out information about the health status of their employees and their dependents. Multiple rate quotes from a carrier would tell employers how much each of the enrollees is contributing to the premium cost (including the health status impact), which the Texas small group laws may not allow.

Finally, we need to take into account the impact on the individuals placed into the Pool. In order to not disadvantage this group, there would need to be some sort of requirement that the coverage they get in the Pool (benefits, cost sharing, provider options) is not worse than what they would get in the small employer's group coverage. The current small employer legislation attempts to protect these high-risk individuals by not allowing employers to pressure them not to enroll. They are ensured the same coverage as the rest of the enrollees. This protection would be difficult to duplicate in legislation for a buy-in.

Consideration of Overhaul of "Baby Group" Market

The discussion above of the market impact of a buy-in focuses on the impact of a buy-in program in the current environment, assuming few other changes. While we believe an Individual Buy-In may not be feasible for the reasons cited above, it may be worth giving further consideration to an overhaul of the "baby group" market (groups under 5 or 10 employees) that includes a Group Buy-In.

For example, we can consider the impact if, along with opening up the Pool to the smallest groups, the rate band restrictions and other requirements are eliminated or relaxed for these groups. This would make the handling of uninsurables in the small group market more similar to the approach in the individual market and would result in a different way of spreading the costs of the high-risk population across the insurance market than exists currently. In addition, this may allow carriers to design products and marketing strategies specifically for this segment of the market.

There may be a number of potential advantages to an overhaul of the baby group market that includes the following elements:

- Baby groups are allowed to buy into the pool for the entire group;
- Rate bands for baby groups are widened or eliminated;
- Carriers are allowed to offer different products to baby groups than to larger small groups;
- Carriers are allowed to perform different levels of underwriting for baby groups than for larger small groups;

- Mandated benefits for baby groups become the same as for individual health coverage;

- The small employer reinsurance pool is eliminated;

- THIRP expands its assessment base to include small employer and stop-loss coverages.

Note that HIPAA requires guaranteed issue for group sizes of 2 and above, so that element of the small group law cannot be impacted.

Spread of Risk Across Markets

For this discussion, it may be useful to look at how the excess costs of high risk groups and individuals are currently subsidized and compare that to the impact of the scenario described above.

Current Environment – High Risk Population Enrolled in Small Groups

Currently there are rating restrictions for small employer carriers that limit the amount of risk load they can charge a small group. In addition, health insurers cannot deny coverage to particular small groups or individuals within small groups. Therefore, they are required to enroll some groups for which they cannot charge a sufficient premium. Going back to the 4 life group above, the needed monthly premium might be $2000 a month, while the maximum rate that can be charged is $1280. These excess costs must be spread over all of the carrier's small group business, increasing the rates for all small employers who have coverage with that particular carrier. In addition, the carrier can choose to share a portion of this risk with other carriers through the small employer reinsurance pool (although the largest health insurers in the State are not participating in this pool).

Current Environment – High Risk Population Without Group Coverage

On the other hand, in the individual market, carriers are not required to issue coverage to all individuals and are not restricted in their risk loads. High risk individuals who desire and can afford coverage can enroll in the Pool. The Pool premiums are not sufficient to cover the costs for these enrollees, so excess costs are paid for through health insurer assessments, with allocations based on the premium volume of each carrier. Small employer premiums are excluded from the allocation base (presumably because they may be subject to small employer reinsurance pool assessments). The carriers have to increase their premiums to cover the costs of the assessments; therefore, the costs are spread to all insureds who have individual or large group health insurance in the state, increasing the general premium levels in these markets.

Group Buy-In Program

Now consider the spread of risk under the "overhaul" scenario described above. The higher cost groups from the small employer market in this scenario would go into the THIRP (assuming they can get a price break by doing so). The excess costs from these groups would now be spread across all health insurance premiums included in the assessment base, rather than only across the small employer premiums of the insuring carrier.

Note that THIRP is exploring ways to expand its assessment base to include self-insured employers through an assessment on stop-loss carriers on a "per covered life" basis. If this were successful, it would allow the excess risks of the baby groups to be spread across essentially the entire health insurance market in the State.

Current Challenges in the Baby Group Market

As noted in our recent survey of small employer carriers, a number of the carriers' comments relate to the difficulty in controlling adverse selection and maintaining a level playing field on the baby groups. Prior to the small group legislation, these smaller group sizes were not generally considered by carriers to be part of the same market segment as 40 or 50 life groups, for valid business reasons. While their inclusion in the small group legislation was intended to help the smallest groups, perhaps it has hurt them and larger groups as well. For example:

- Carriers must offer the same products to all group sizes within the entire small group market. This limits their ability to tailor their product offerings as they would like or as may be reasonable, for example with lower cost standardized options for the smallest groups and multiple choice offerings for the larger groups.

- Mandated benefits that may be supportable for 50 life groups can be cost prohibitive for smaller groups.

In addition, the inclusion of groups down to 2 lives may be increasing overall small group rates because:

- The better risks in the smallest group sizes may be going into the individual market, where they may secure better rates.

- The better risks in the largest group sizes may be able to get better rates by self-funding (because if they self-fund, they do not need to subsidize the smaller or sicker groups).

An overhaul of the baby group market may be able to address some of these concerns.

Potential Advantages and Challenges

As noted earlier, there are a number of potential advantages to implementing a Group Buy-In along with other major changes in the baby group market. Most importantly:

- This approach may help to control costs throughout the small employer market (up to 50 lives), which is particularly price-sensitive. Most advocates of State high risk pools believe that these pools not only help the uninsurable population, but also help to stabilize the private individual health insurance market in the State. The same reasoning may apply in the small group market.

- Carriers could have more leeway in designing lower cost products for baby groups. The lower costs would come from having fewer mandated benefits and less adverse selection risk through product design and underwriting, as well as from allowing carriers to focus solely on the market needs of these baby groups rather than the entire range of small groups.

However, there would also be a number of challenges. For the scenario to work as illustrated, a number of changes would need to be implemented. These changes would represent a huge departure from the status quo in the small group market. Significant questions include:

- Whether these changes would leave a viable market (i.e., willing carriers) for private coverage of baby groups;

- Whether these changes would leave a viable market for the private coverage of group sizes from 5 or 10 to 50 lives;

- Whether the resulting redistribution (through assessments) of excess costs is equitable;

- Whether the THIRP can handle the additional lives and administration of an expansion of the program;

- Whether the approach would truly materially impact small employer premium rates and the number of uninsureds in the State in a positive way.

Conclusions

The opportunity for small employers to buy into the Risk Pool, on either an individual or group basis may assist high-risk groups in attaining health insurance at a lower cost. The excess costs for these groups would need to be borne by other players in the health insurance market.

There are a number of challenges to an Individual Buy-In that would make it difficult or impossible to implement. A Group Buy-In, without a number of other changes, may not provide many advantages to the small employer market. A Group Buy-In implemented with a number of other changes in the baby group market may be feasible and offer some relief and stability to the small employer market. However, this would require a major overhaul of the small group market, with significant short-term disruption, with no guarantee of successful results."

(Report Attachment Below)

Development of Relative Rates
Small Employer Buy-In to Texas Health Insurance Risk Pool

Monthly Rate	Market	Development
$200	Individual Health Rate, New Business, Preferred	Starting Assumption
$120	Individual Health Claim Costs, New Business, Preferred	60% Individual Health Target Loss Ratio
$160	Small Group Premium Rate, Size > 30, Preferred	$120 / 75% Target Loss Ratio
$192	Small Group Premium Rate, Size < 10, Premium Rate, Preferred	$160 x 1.2 Group Size Loading Factor
$267	Maximum Premium Rate, Size > 30	$160 x 1.67 Group Size Loading Factor
$320	Maximum Premium Rate, Size < 10	$192 x 1.67 max small group loading
$400	Pool Rate	200% of individual health rate

September 28, 2004 – Assessment of Small Group Market Issues for the Texas State Planning Grant – Report by Milliman USA to Texas Department of Insurance

In a report to TDI dated January 15, 2003, "… Milliman discussed options for designing a buy-in to the Texas Health Insurance Risk Pool (THIRP). That letter discussed the possibility of an individual buy-in to the Pool and determined that such a program is not likely to be feasible. We defined an individual buy-in to mean that an employer could secure health insurance for one or more of his higher risk employees in the Pool while purchasing small employer coverage through a private carrier for his healthier employees. Please refer to the January 2003 letter for a discussion of an individual buy-in program." (Note: text provided above)

"In that letter we also suggest that a group buy in approach may be considered as part of a broad strategy to reform the small group market, with an emphasis on change in the baby group market. In this section we describe this approach, which we will refer to as the "Overhaul" scenario, and attempt to quantify the impact of this package of legislative changes.

The Overhaul scenario assumes the following changes from the current environment:

- Baby groups are allowed to buy into the Pool as an entire group;
- Rate bands for baby groups are widened or eliminated (in our modeling, we assume they are widened slightly for all small groups);
- Carriers are allowed to offer different health insurance plan designs to baby groups than to other small groups;
- Mandated benefits for baby groups are revised and differ from those for larger small groups;
- The small employer reinsurance pool is eliminated;
- THIRP expands its assessment base to include small employer and stop-loss coverages.

Note that HIPAA requires guaranteed issue for group sizes of 2 and above, so that element of the small group law cannot be impacted. With respect to the mandated benefit changes, a reasonable approach may be to remove all required "offerings" for baby groups. For baby groups, there may be significant adverse selection associated with required offerings that cannot be handled in the rider pricing. The smaller the group, the more adverse selection occurs in an environment where coverage is offered rather than mandated. This is less of an issue with the larger small groups.

Model Description

The market change model is shown in Exhibit 4. The top half of the page shows estimates of premiums, lives and THIRP assessments under current market assumptions. The bottom half shows adjusted information assumed under the Overhaul scenario.

Current Market Description

The first column shows the estimated number of people, by market, in Texas with comprehensive coverage in 2003 (in thousands). These are estimates of the total covered members, including dependents. The count is not intended to include individuals with limited coverages such as specified disease or hospital indemnity policies. We have also attempted to exclude members covered under FEHBP, because FEHBP premium is excluded from the THIRP assessment base. We show fully insured lives split among large group, small group with less than 10 employees, small group with 10-50 employees, and individual coverage. We then show the estimated self-insured lives who are in plans covered under stop-loss reinsurance and the total covered insured and self-insured. The average number of THIRP enrollees in 2003 is shown on the following line.

The next column shows the estimated annual premium per member in each of the markets. For the self-insured line, this premium represents the "equivalent premium". In other words, it represents an estimate of the annual self-insured claim costs plus administrative costs plus the cost of stop-loss coverage.

The third column shows the estimated total premium and equivalent premium in $ billions for each market. It is calculated as the product of the first two columns divided by 1 million.

Next we show the number of subscribers, i.e., employees or individual policies. A proposed methodology for revising the THIRP assessment uses this count as the assessment base. For group coverages, it represents the number of employees. For individual health insurance, it represents the number of policies; i.e., a family policy would count as one.

The last two columns show the allocation of the 2003 THIRP assessment to the various markets, based on the 2003 assessment base. The $68.9 million loss in the Pool was allocated based on premium dollars and only applied to the fully-insured large group and individual markets. The assessment represented approximately 0.92% of assessable premium.

Current Market Data Sources and Assumptions

In order to develop the covered lives estimates, we started with special runs of data provided by the Employee Benefit Research Institute (EBRI) for Milliman.

The values we receive from EBRI reflect the number of insureds within a particular group size, insured through groups (whether fully insured or self-insured), or via associations or individual policies.

We made assumptions with respect to the percentage in each market that is fully insured vs. self-insured and the portion of the insured who have comprehensive coverage. We also estimated the portion of the self-insured who have stop-loss coverage.

The average monthly premiums per member are from cost models based on Milliman's *Health Cost Guidelines*, a database of healthcare costs and adjustment factors. The premium differences among markets reflect different assumptions with respect to benefit plan design, demographics, health status, and target loss ratios.

In developing our covered lives assumptions for the insured markets, we made adjustments to result in total premium dollars that are consistent with the dollars reported to THIRP for its 2003 assessment. The total assessment base for the 2003 assessment was $7.5 billion, which is the sum of the large group and individual lines in the current market scenario. Carriers reported $3.5 billion in small group premium to the Pool and in separate annual reports submitted to TDI (Figure 48 filings). We did not have any secondary sources to allow us to verify the covered lives estimates for self-insured with stop-loss, as there are no specific reporting requirements in Texas.

We assumed an average family size of 1.9 in all markets in order to develop the number of subscribers from the total covered lives. While this may vary somewhat among the markets, such variance does not have a significant impact on the results.

The 2003 regular assessment and average number of members for the THIRP are based on the Pool's 2003 Annual Report to the Governor.

Overhaul Scenario Description and Assumptions

The bottom of Exhibit 4 shows the same columns and line items as for the current market. However, the second and third columns are expressed before the impact of assessments. We have adjusted the number of insureds and annual premium per member to reflect the expected impact of the Overhaul package of changes.

All of the changes assume that the rating bands are expanded for all small groups. Currently, small group carriers can apply a "health status loading" factor that is 67% greater for the groups with the worst health status than the factor for groups with the best health status. This is based on an allowable variance from an index rate of +/- 25% ((1 + .25)/(1 - .25) = 1.67).

In our model, we assumed an allowable variance from an index rate of +/- 33⅓%. This results in a maximum health status factor that is 200% of the minimum factor ((1 + .33)/(1 - .33) = 2.00).

We have assumed that there is no change to the 20% group size loading limit. It is important to note, however, that if different benefit plans and underwriting approaches are allowed in the baby group market, it may be difficult to prevent carriers from implicitly applying an additional loading in this market.

We estimate that with the +/- 33⅓% rate band, the maximum rates in the baby group market will be in the same neighborhood as the Pool rates. Therefore, in most cases, there will be no price advantage to an employer to go to the Pool. However, the Pool will represent true maximum rates that baby groups can secure for plan designs equivalent to those offered by the THIRP.

Based on modeling of revised premiums under the new rate bands, we developed the following adjustments to get from the current to the Overhaul scenario:

- 2.5% of the baby groups move to the Pool (assumes 25% of the formerly highest rated groups will move);
- Small group rates will go down by 1.4% due to the expansion of the rate bands;
- Baby group rates will go down 1.0% due to movement of higher–cost groups to the Pool.

We also assumed that the average baby group rate would go down by 5% to reflect availability of less expensive plan designs.

Based on the movement assumption, we would expect the average THIRP membership to be about 34,500 rather than the 23,300 actual 2003 average. We have assumed that the Pool losses would go up proportionately from the actual $68.9 million, to $102.0 million.

The allocation of this $102.0 million is based on the number of subscribers, including those self-insured with stop-loss. It results in an assessment of $23.88 per subscriber per year, which translates into about 0.47% of premium. The percentage varies slightly in the different markets, from .42% of premium for baby group and individual premium and .48% of large group and self-insured premium and equivalent premium.

When you add the assessments into the average annual premium per member, you can compare the resulting average premiums to the average premiums in the

current market scenario. The last column shows the ratio of the Overhaul premium per member to the current premium per member.

Results

As you can see from the last column of the model, the Overhaul scenario does not result in significant price breaks (or significant additional costs) for any market segments.

For large group, small group sizes 10 – 50, and individual coverage, the result is less than a 1% reduction in premiums. Self-insured equivalent premiums would go up about 0.5% due to the introduction of THIRP assessments. The model shows almost a 7% reduction for small groups with less than 10 employees; however, 5% of that reduction results from assumed reductions in benefit plan values.

Based on the model assumptions and results, and Overhaul approach would not yield enough change in premium levels to measurably impact the uninsured numbers in the State. However, it may be worth exploring for other reasons. Following, we discuss the potential advantages and challenges.

Other Potential Advantages of Baby Group Market Overhaul

Even in the absence of significant premium reductions that could materially impact the uninsured population, there are a number of potential advantages to implementing a Group Buy-In along with other major changes in the baby group market. Most importantly:

- The Overhaul scenario results in a broader and potentially more equitable spread of risks across the health insurance market in the State. Currently, the larger small employer carriers are exempt from both THIRP assessments and Reinsurance Pool assessments if they are designated as “risk-assuming” carriers. While fully insured large employers pay a share of the THIRP assessment, self-insured employers do not. Both of these market segments would be rolled into the assessment base in the Overhaul assumptions.

- The approach may help to control costs throughout the small employer market (up to 50 lives), which is particularly price-sensitive. Most advocates of State high risk pools believe that these pools not only help the uninsurable population, but also help to stabilize the private individual health insurance market in the State. The same reasoning may apply in the small group market.

- Carriers could have more leeway in designing lower cost products for baby groups. The lower costs would come from having fewer mandated

benefits and less adverse selection risk through product design and underwriting, as well as from allowing carriers to focus solely on the market needs of these baby groups rather than the entire range of small groups.

- It would result in a true "ceiling" for baby group rates; employers would have a second option if carrier rate manuals put their rates above the Pool rates.

We discuss the first bullet-point in more detail here. For this discussion, it may be useful to look at how the excess costs of high-risk groups and individuals are currently subsidized and compare that to the impact of the Overhaul scenario.

Current Environment – High Risk Population Enrolled in Small Groups

Currently there are rating restrictions for small employer carriers that limit the amount of risk load they can charge a small group. In addition, health insurers cannot deny coverage to particular small groups or individuals within small groups. Therefore, they are required to enroll some groups for which they cannot charge a sufficient premium. For example, the needed monthly premium for a particular 4-life group might be $2000 a month, while the maximum rate that can be charged is $1280. The excess costs must be spread over all of the carrier's small group business, increasing the rates for all small employers who have coverage with that carrier. In addition, the carrier can choose to share a portion of this risk with other carriers through the small employer reinsurance pool (although the largest health insurers in the State are not participating in this pool).

Current Environment – High Risk Population Without Group Coverage

On the other hand, in the individual market, carriers are not required to issue coverage to all individuals and are not restricted in their risk loads. High-risk individuals who desire and can afford coverage can enroll in the Pool. The Pool premiums are not sufficient to cover the costs for these enrollees, so excess costs are paid for through health insurer assessments, with allocations based on the premium volume of each carrier. Small employer premiums are excluded from the allocation base (presumably because they may be subject to small employer reinsurance pool assessments). The carriers have to increase their premiums to cover the costs of the assessments; therefore, the costs are spread to all insureds who have individual or large group health insurance in the state (excluding self-insured coverages), increasing the general premium levels in these markets.

Overhaul Scenario

Now consider the spread of risk under the Overhaul scenario described above. The higher cost groups from the baby employer market in this scenario would go

into the THIRP along with the current enrollees. The excess costs from these groups would now be spread across all health insurance premiums included in the assessment base, rather than only across the small employer premiums of the insuring carrier.

If the THIRP assessment base is expanded to include self-insured employers through an assessment on stop-loss carriers on a "per covered life" basis, the excess risks of the baby groups would be spread across essentially the entire health insurance market in the State. This will result in some minor redistribution of average costs and premiums as described earlier.

Challenges and Considerations

There would also be a number of challenges associated with the Overhaul scenario. Following are some issues for consideration:

- The modeling illustrated in this report assumes that the Pool pricing continues to be based on market rates for individual coverages. With the introduction of baby groups, small group market rates may need to be taken into account as well. This would require collecting data from carriers that is currently not available and performing additional data analysis in setting the Pool rates.

- The added flexibility in plan design and marketing to baby groups could result in a higher effective group size adjustment than is currently allowed, if, for example, carriers artificially increase the "plan factors" for those plan designs only sold to baby groups with the intention of pricing themselves out of that market. Note that if this is the case, more groups would be able to find lower rates in the Pool than from private carriers than we have assumed.

- The model assumes an expansion of the rate bands for all small groups. While this is expected to lower the aggregate average premium, rates for the sickest groups will go up. As noted earlier, however, there will effectively be a ceiling on rates for the baby groups equal to the Pool rates.

- The expansion would require the THIRP to administer additional lives and an expansion of the program.

The biggest potential challenge associated with the Overhaul scenario may be the number of legislative changes that would be required. The following section, therefore, addresses the impact of compromise legislation that does not include all aspects listed.

Impact of Half-Measures

The Overhaul scenario would require a significant number of legislative changes. These changes would represent a huge departure from the status quo in the small group market. Even with support for such an overhaul, it is likely that some of the changes would pass while others would not. Following is a discussion of the importance of each of the components described earlier and the impact of not including it as part of the Overhaul package:

- *Baby groups are allowed to buy into the Pool for the entire group.* This is the major premise behind the modeling. However, the model still has application even in the absence of this legislative change in estimating the impact of changing the assessment methodology for the THIRP. Of course, if eligibility for the Pool is not expanded, there is less of an argument for including small group premiums in the assessment base.

  Exhibit 5 shows the impact of four different methodologies for allocating THIRP assessments. The top of the exhibit shows the results of different assessment allocations, keeping all other assumptions consistent with the Current Market scenario. The four methodologies and the results are as follow:

  - The "2003 Basis" allocates the Pool losses as a percentage of insured premium. The base does not include small group premiums. As noted earlier, this results in assessments of 0.92% of premium for fully insured large group and individual premiums.

  - The "Overhaul" method allocates the Pool losses based on the number of subscribers in each market. It includes small group and self-insured (stop-loss) coverage. This results in an assessment of .28% - .32% of premium for all markets.

  - "Per Subscriber excluding Small Group" is the same as the Overhaul method, but it excludes small group subscribers. It results in assessments of .38% of premium (or equivalent premium) for large group and self-insured blocks, and .33% for individual coverage.

  - "% of Insured Premium Including Small Group" is the same as the 2003 basis, but it includes small group insured premium. It results in an assessment of .63% of premium for large group, small group, and individual coverages.

- *Rate bands for baby groups are widened or eliminated.* If there is no change in this area, the likelihood of a group receiving better rates in the Pool than in the small group commercial market becomes even less. In

theory, maximum rates in the small group market will be less than the Pool rates without this change.

- *Carriers are allowed to offer different products to baby groups than to other small groups.* If this change is not enacted, it removes one of the potential advantages of the Overhaul model.

- *Mandated benefits for baby groups are revised and differ from those for larger small groups.* As with the prior change, if this is not part of the Overhaul package, it removes one of the potential advantages of implementing changes to the baby group market.

- *The small employer reinsurance pool is eliminated.* This change would be a necessary prerequisite for rolling small employer premiums into the THIRP assessment. Without this change, small employer carriers who pay assessments into the reinsurance pool would likely balk at also paying the THIRP assessment.

- *THIRP expands its assessment base to include small employer and stop-loss coverage.* If small employers are allowed to buy into the Pool, it will be critical that the premiums from the market are included in the assessment base. The expansion of the assessment methodology to include stop-loss coverage adds to the attractiveness of the overhaul because essentially all types of comprehensive health care coverage would end up with some loading for the uninsurables. However, even without this expansion, many of the potential advantages of the remainder of the overhaul would remain.

The bottom of Exhibit 5 shows the results if all aspects of the Overhaul scenario are as described except for the Pool assessment methodology. If stop-loss coverage is not included, a reasonable alternative is to continue with an allocation based on a percent of insured premium, but with small group coverage included in the base. This is the fourth method shown. It is expected to result in an assessment of .94% of premium for all insured coverages.

CONCLUSION

…The Baby Group Overhaul Model defines a package of legislative changes that may promote stability of the health insurance market, as well as result in a more equitable spread of risk to the entire covered population. However, such sweeping changes would be difficult to achieve and are likely to do little to address the uninsured issue. While the legislative changes could come piecemeal, the intended results are less likely to be achieved in this manner."

Exhibit 4: Market Change Model

Current Market Summary

Summary of Lives, Premiums, Policies

Allocation of THIRP Assessment
2003 Assessment ($ millions)=$68.9

Market	Number with Comp. Covg. (000s)	2003 Est. Avg. Annual Premium per Member	2003 Est. Total Prem. and Equiv. In $ Billions	Number of Ees or Indiv. Policies (000s)	2003 Basis Total (Millions)	2003 Basis % of Prem and Equiv.
		[Implicitly Include Assessments]				
Fully Insured Comprehensive Coverage						
Large Group	1,976	$2,633	5.2	1,040	47.7	0.92%
Small Group <10 Employees	447	$3,245	1.5	235	-	0.00%
Small Group 10-50 Employees	757	$2,704	2.0	399	-	0.00%
Total Small Group	1,204	$2,905	3.5	634	-	0.00%
Individual Coverage	772	$3,000	2.3	406	21.2	0.92%
Total Fully Insured	3,952	$2,788	11.0	2,080	68.9	0.63%
Self-Insured With Stop-Loss	4,170	$2,626	10.9	2,195	-	0.00%
Total Insured Plus Self-Insured	8,122	$2,705	22.0	4,275	68.9	0.31%
THIRP	23.3					

Overhaul Scenario

Summary of Lives, Premiums, Policies

Allocation of THIRP Assessment
Overhaul Assessment ($ millions)=$102.0

Market	Number Ins'd Comp. Covg (000s)	2003 Adjusted Avg. Annual Premium per Member	2003 Est. Total Prem. and Equiv. in $ Billions	Number of Ees or Indiv. Policies (000s)	Overhaul Method Total ($ms)	Overhaul Method Per Yr. Per Subscriber	Overhaul Method % of Prem. and Equiv.	Avg. Annual Prem. Per Member Including Assessments	Ratio of Overhaul Premium per Member to Current
		[Excluding Assessments]							
Fully Insured Comprehensive Coverage									
Large Group	1,976	$2,609	5.2	1,040	24.8	23.88	0.48%	2,622	0.996
Small Group <10 Employees	436	$3,012	1.3	229	5.5	23.88	0.42%	3,025	0.932
Small Group 10-50 Employees	757	$2,668	2.0	399	9.5	23.88	0.47%	2,680	0.991
Total Small Group	1,193	$2,793	3.3	628	15.0	23.88	0.45%	2,806	0.966
Individual Coverage	772	$2,973	2.3	406	9.7	23.88	0.42%	2,985	0.995
Total Fully Insured	3,941	$2,736	10.8	2,074	49.5	23.88	0.46%	2,749	0.986
Self-Insured With Stop-Loss	4,170	$2,626	10.9	2,195	52.4	23.88	0.48%	2,639	1.005
Total Insured Plus Self-Insured	8,111	$2,680	21.7	4,269	102.0	23.88	0.47%	2,692	0.995
THIRP	34.5								

Exhibit 5: Market Change Model

Current Market Summary

Market	2003 Basis (% LG & Ind. Prem.)			Overhaul (Per Subscriber)			Per Sub. Excl. Small Group			% of Insured Prem. Incl. Sm. Grp.		
	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.
Fully Insured Comprehensive Coverage												
Large Group	47.7	45.85	0.92%	16.8	16.12	0.32%	19.68	18.93	0.38%	32.5	31.29	0.63%
Small Group <10 Employees	-	-	0.00%	3.8	16.12	0.26%	-	-	0.00%	9.1	38.56	0.63%
Small Group 10-50 Employees	-	-	0.00%	6.4	16.12	0.31%	-	-	0.00%	12.8	32.13	0.63%
Total Small Group	-	-	0.00%	10.2	16.12	0.29%	-	-	0.00%	21.9	34.52	0.63%
Individual Coverage	21.2	52.23	0.92%	6.6	16.12	0.28%	7.69	18.93	0.33%	14.5	35.65	0.63%
Total Fully Insured	68.9	33.12	0.63%	33.5	16.12	0.30%	27.4	13.16	0.25%	68.9	33.12	0.63%
Self-Insured With Stop-Loss	-	-	0.00%	35.4	16.12	0.32%	41.53	18.93	0.38%	-	-	0.00%
Total Insured Plus Self-Insured	68.9	16.12	0.31%	68.9	16.12	0.31%	68.9	16.12	0.31%	68.9	16.12	0.31%
THIRP												

Overhaul Scenario

Market	2003 Basis (% LG & Ind. Prem.)			Overhaul (Per Subscriber)			Per Sub. Excl. Small Group			% of Insured Prem. Incl. Sm. Grp.		
	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.	Total ($ms)	Per Yr. Per Sub.	% of Prem and Equiv.
Fully Insured Comprehensive Coverage												
Large Group	70.5	67.85	1.35%	24.8	23.88	0.48%	29.12	28.00	0.56%	48.7	46.87	0.94%
Small Group <10 Employees	-	-	0.00%	5.5	23.88	0.42%	-	-	0.00%	12.4	54.11	0.94%
Small Group 10-50 Employees	-	-	0.00%	9.5	23.88	0.47%	-	-	0.00%	19.1	47.92	0.94%
Total Small Group	-	-	0.00%	15.0	23.88	0.45%	-	-	0.00%	31.5	50.18	0.95%
Individual Coverage	31.4	77.29	1.35%	9.7	23.88	0.42%	11.38	28.00	0.50%	21.7	53.40	0.94%
Total Fully Insured	102.0	49.15	0.94%	49.5	23.88	0.46%	40.5	19.52	0.38%	102.0	49.15	0.94%
Self-Insured With Stop-Loss	-	-	0.00%	52.4	23.88	0.48%	61.46	28.00	0.56%	-	-	0.00%
Total Insured Plus Self-Insured	102.0	23.88	0.47%	102.0	23.88	0.47%	102.0	23.88	0.47%	102.0	23.88	0.47%
THIRP												

OUTLINE OF COVERAGE
Individual Major Medical Coverage

Policy and Medical Claims Administered By:	**Blue Cross and Blue Shield of Texas***
Address:	**P. O. Box 6089, Abilene, TX 79608-6089**
Toll Free Number:	**1-888-398-3927**
	(Administrator)
Pharmacy Program Administered By:	**WellPoint Pharmacy Management, Inc.**
Address:	**P. O. Box 4496 Woodland Hills, CA 91365-4496**
Toll Free Number:	**1-866-302-7164**
	(Pharmacy Manager)

The Texas Health Insurance Risk Pool (the Pool) was created by the Texas legislature to offer health insurance to residents of the state through participation of health insurance companies. This program is designed to provide health insurance to those Texas residents who are unable to obtain adequate health coverage due to their medical condition or who are considered Federally Eligible Individuals as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Pool. It is, therefore, important that You **READ YOUR POLICY CAREFULLY! Your application and Your acceptance of the Policy, if issued, constitute Your agreement to the terms and limitations of the Policy.**

II. This Policy is designed to provide eligible individuals with coverage for major hospital, medical, and surgical expenses, incurred as the result of a covered injury or sickness. Only eligible individuals and their Dependents and Family Members are eligible for coverage by the Pool.

A. Eligibility for Coverage

1. You are eligible for coverage by the Pool if You are under age 65 and You are and remain a legal resident of Texas and You provide evidence that You have maintained Health Insurance coverage for the 18 months preceding Your application for coverage to the Pool, with no gap in coverage greater than 63 days, provided the last Health Insurance was through an employer sponsored plan, church plan, government plan or another state's high risk pool.
2. You are eligible for coverage by the Pool if You are under the age of 65 (or over the age of 65 and not enrolled in Medicare Part B), and remain a legal resident of Texas and You provide evidence that You are certified as eligible under Trade Adjustment Assistance or the Pension Benefit Guaranty Corporation (collectively, the HCTC Program).
3. You are also an eligible individual if You are under age 65, have been for at least 30 days and remain a legal resident of Texas and a United States citizen or a permanent resident of the United States for at least three continuous years, and You provide evidence to the Pool's Administrator of one of the following:
   a. A notice of rejection or refusal to issue substantially similar individual Health Insurance to You for health reasons by an Insurance Company;
   b. A certification from an agent or salaried representative of an Insurance Company, on the Pool's Application form, that states the agent or representative is unable to obtain substantially similar individual Health insurance for You with any state-licensed Insurance Company, which the agent or representative represents, because You will be declined for coverage, as a result of Your medical condition, under the underwriting guidelines of the Insurance Company.
   c. An offer by an Insurance Company to issue substantially similar individual Health Insurance to You only with conditional riders, which exclude coverage for medical conditions;

d. An offer by an Insurance Company to issue substantially similar individual Health Insurance to You at a premium rate greater than the current rate charged by the Pool; or

e. You have been diagnosed with one of the following medical conditions, determined as a condition for automatic eligibility by the Pool Board of Directors:

- Cancer
  - Malignant Tumor within 4 years (except skin cancer)
  - Metastatic
- Cardiovascular
  - Artificial Heart Valve
  - Cardiomyopathy
  - Coronary Artery Disease
  - Polyarteritis Nodosa
  - Peripheral Vascular Disease, including Intermittent Claudication
- Endocrine/Exocrine
  - Diabetes Mellitus
  - Cystic Fibrosis
  - Addison's Disease
- Gastrointestinal
  - Intestinal
    - Crohn's Disease
    - Ulcerative Colitis
  - Liver
    - Cirrhosis (non-alcoholic)
    - Wilson's Disease
    - Hepatitis
- Hematopoietic
  - Anemia
    - Sickle Cell
    - Splenic (True Banti's Syndrome)
  - Hemophilia
  - Leukemia
  - Thalassemia
- Hodgkin's Disease
- Immunological
  - Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive
  - Lupus
- Musculoskeletal
  - Dermatomyositis or Polymyositis
  - Muscular Atrophy or Dystrophy
  - Myotonia
  - Rheumatoid Arthritis
  - Still's Disease
  - Legge-Perthes Disease (Waldenstrom's Disease)
- Neurological – Central Nervous System
  - Cerebral Palsy
  - Cerebral Vascular Accident (CVA)
  - Epilepsy
  - Huntington's Chorea
  - Hydrocephalus
  - Lead Poisoning with Cerebral Involvement
  - Lobotomy
  - Parkinson's Disease (if treatment within last 3 years)
  - Guillian-Barre Syndrome
- Neurological – Peripheral Nervous System (including Spinal Cord)
  - Amyotrophic Lateral Sclerosis (ALS)
  - Friedrich's Ataxia
  - Myasthenia Gravis
  - Paraplegia or Quadriplegia
  - Sclerosis, Multiple, Disseminated or Postero-lateral
  - Syringomyelia
  - Tabes Dorsalis (Locomotor Ataxia)
- Psychiatric
  - Psychotic Disorders
- Pulmonary
  - Silicosis (Black Lung)
- Renal
  - Polycystic Kidney
- Other
  - Brain Tumor
  - Down's Syndrome
  - Scleroderma
  - Transplants
    - Heart
    - Kidney
    - Liver
    - Lung

4. Dependents: Your Dependents are also eligible for coverage by the Pool. If the eligible individual is a child, Family Members of the child who have been for at least 30 days and remain legal residents of Texas and United States citizens and who reside with the child are also eligible for coverage by the Pool.

B. Persons Not Eligible

Even if You meet an eligibility requirement above, You are not eligible for coverage by the Pool if You:

1. Have other Health Insurance in effect on the date Pool coverage would otherwise be effective (This does not apply to eligibility under the HCTC Program. In the case of coverage by Medicare, You are allowed to retain Medicare coverage if You otherwise qualify for the Pool. The Pool's coverage will be secondary to coverage provided by Medicare. In the case of an individual policy of health insurance, You will be required to terminate such individual policy within 60 days after the effective date of a Pool policy);
2. Are eligible for or covered by employer-sponsored Health Insurance, including a self-insured health benefit plan, including eligibility for continuation of coverage under state or federal law (If You are or were eligible for COBRA or state mandated continuation, You are not eligible for Pool coverage until the scheduled termination of such continuation, even if You do not elect the continued coverage); except:
   a. coverage, continued under state or federal law, maintained for the period of time necessary to satisfy any Preexisting Condition limitation period for Pool coverage (does not apply to eligibility under the HCTC Program); or
   b. an employer group plan, church plan or government coverage that either excludes an individual or limits coverage for an individual by medical condition waivers; a pre-existing condition limitation of a benefit plan does not constitute an exclusion or a medical condition waiver of an individual (does not apply to eligibility under the HCTC Program).

   Note: If You or Your dependents were covered by prior group coverage, You and Your dependents may be eligible for COBRA or state continuation of coverage. If an individual is eligible for COBRA or state-mandated continuation, the individual is not eligible for Pool coverage until the scheduled termination of such continuation coverage, even if the continuation coverage was not elected by the individual. A dependent, covered under the terminating prior group coverage, is entitled to continuation, regardless of the continuation election of the employee.
3. Are covered by individual Health Insurance, except that an individual is eligible for Pool coverage if: the individual coverage limits coverage for an individual by a medical condition waiver; or the premium rate for the individual coverage is higher than the current Pool premium rate. If You become covered by the Pool, the other individual coverage must be cancelled or lapsed within 60 days after the effective date of Pool coverage; until such time as the other coverage is terminated, Pool coverage will be secondary to such other coverage.
4. Have terminated coverage through the Pool within the twelve months preceding Your application for coverage by the Pool, unless You demonstrate a good faith reason for the termination;
5. Are confined to a county jail or imprisoned in a state prison;
6. Have premiums paid or reimbursed by or under any government sponsored program or any government agency or health care provider, unless You qualify as a full-time employee or such employee's dependent of such government agency or health care provider (does not apply to eligibility under the HCTC Program);
7. Had prior coverage by the Pool that was terminated for nonpayment of premiums within the twelve months preceding Your application for coverage by the Pool;
8. Had prior coverage by the Pool that was terminated for fraud; or
9. Have received $1,500,000 in benefits from the Pool under this Policy, including the benefits paid under any other Pool policies.

III. Benefits

A. The benefits outlined in the table below show the payment percentages for Covered Expenses AFTER each Insured Person has satisfied any deductibles. You have a choice of four plans of coverage. Plan I has a $500 Calendar Year Deductible; Plan II has a $1000 Calendar Year Deductible; Plan III has a $2500 Calendar Year Deductible; and Plan IV has a $5,000 Calendar Year Deductible. The Calendar Year Deductible amount selected may not be changed to a lower amount after the Policy is issued. You may request to change to a higher Calendar Year Deductible, if offered by the Pool, but only one such change will be allowed in a calendar year. The change will be effective on the first of the month following the date the Pool receives Your written request for such change or a later date, if You request it.

Covered Expenses are limited to the Allowable Amount determined by the Administrator. For a Preferred Provider, the Allowable Amount is based on the terms of the Preferred Provider network contract and the payment methodology in force on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), relative value, resource based relative value scale (RBRVS), fee schedules, package pricing, global pricing or other payment methodologies. For a Non-Preferred Provider, the Allowable Amount is based on the amount that would have been paid for the same covered service, supply or procedure with an equivalent Preferred Provider.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.

After each Insured Person has paid the applicable deductibles, the Policy will pay the amount of Covered Expenses in excess of the coinsurance amount. For Covered Expenses from a Preferred Provider, once You have paid Your Coinsurance Maximum, the Policy will pay 100% of Covered Expenses from Preferred Providers for the remainder of the calendar year. There is no Coinsurance Maximum for Covered Expenses from a Non-Preferred Provider, including ParPlan Providers. The Policy will never pay 100% for Covered Expenses from a Non-Preferred Provider. In no event will the Policy pay more than the Lifetime Maximum for each Insured Person. Also, the Calendar Year Deductible, the emergency care deductible, physician office visit copayments and charges for outpatient prescription drugs, including charges applied to the prescription drug deductible or copayments, do not count toward the Coinsurance Maximum.

The Calendar Year Deductible and Coinsurance Maximum are accumulated on a calendar year basis, regardless of when Your coverage becomes effective. However, Covered Expenses, which are applied toward the Calendar Year Deductible in the last three months of the year, will also be applied in an equal amount to the Calendar Year Deductible for the next year.

Covered Expenses are charges for services and supplies, which are covered by the Policy, that are not in excess of Allowable Amounts and that are determined to be Medically Necessary for treatment of an illness or injury.

Lifetime Maximum or Lifetime Maximum Amount means the maximum amount of covered expenses payable by the Pool under this Policy and any other Pool policy for each Insured Person. The Lifetime Maximum Amount is $1,500,000.

WHAT YOU PAY	**PLAN I**	**PLAN II**	**PLAN III**	**PLAN IV**
Calendar Year Deductible for each Insured Person	$500	$1000	$2500	$5000
Coinsurance for PPO Providers	20%	20%	20%	20%
Coinsurance for Non PPO Providers	40%	40%	40%	40%
Coinsurance Maximum for PPO Providers (calendar year) for each Insured Person	$3000	$3000	$3000	$3000
Coinsurance Maximum for Non PPO Providers (calendar year) for each Insured Person	None	None	None	None
Lifetime Maximum Amount for each Insured Person	$1,500,000			

BENEFITS

Hospital	Average semi-private room rate No more than one visit per physician per day
Intensive Care or Cardiac Care Unit	No more than 3 times the average semi-private room rate
Assistant surgeon or Surgical First Assistant	One assistant, no more than 25% of the primary surgeon's fee
Hospital or other facility for Emergency Care	Subject to additional $75 deductible per visit
Physician Office Visit (**Preferred Providers Only**)	$30 copayment per visit, two visits per calendar year Visits after first 2, subject to Calendar Year Deductible & Coinsurance
Physical, Occupational, Speech Language Therapy	Combined maximum benefits of one visit per day & 12 visits per calendar year
Skilled Nursing Facility	45 days per calendar year
Home Health Care	Calendar year maximum benefit of lesser of 60 visits or $5,000
Hospice Care	Lifetime maximum benefit of lesser of 180 days or $10,000
Ambulance	Calendar year maximum benefits of $2,000 ground & $5,000 air
Named Transplants	$300,000 combined lifetime maximum benefit
Serious Mental Illness	Calendar year maximum benefit of 30 inpatient days and 50 outpatient visits
Preauthorization Provisions	If a preauthorization requirement is not met, benefits for covered expenses will be reduced 50%

Other Benefits (see Policy for specific benefits)

- Acquired brain injury
- Anesthesia
- Blood
- Breast reconstruction in connection with mastectomy
- Colorectal screening
- Complications of Pregnancy (no coverage for normal maternity)
- Diabetes equipment, supplies and self-management training
- Durable medical equipment
- Genetic Testing and Counseling
- Growth Hormone Treatment
- Home infusion therapy
- Miscellaneous Hospital services and supplies
- Outpatient care
- Outpatient contraceptive services
- Oxygen
- Preadmission Testing
- Preventive Care
- Prosthetic devices
- Radiation therapy, inhalation therapy, chemotherapy
- Second Surgical Opinion
- Surgeons
- Surgical services and supplies from an Ambulatory Surgical Center and Hospital outpatient facility
- X-rays and laboratory tests

B. Preauthorization and Case Management Provisions

The special features listed below allow You access to the medical care You need, while they reduce the costs to You and the Pool.

1. Preauthorization: Information is reviewed by medical personnel to authorize specific services. Preauthorization is required for the following medical services: inpatient hospital admissions, up to a combined maximum of 24 additional visits for physical, occupational and/or speech therapy following an inpatient hospitalization for severe trauma, skilled nursing facility admissions, home health care services, home infusion therapy, hospice care, durable medical equipment over $2,000 and organ and tissue transplants. It is necessary to contact the Administrator prior to obtaining such services. **If the service is not preauthorized, the benefit for the service will be reduced by 50%.** In addition, certain benefits administered by the Pharmacy Manager are subject to Prior Authorization. Please see the Prescription Drug benefit description for details.
2. Case management: The case manager will work with You and Your physician to determine the appropriate level of care You need.

C. BlueChoice® Network

The Pool has selected the BlueChoice® Network as the Pool's Preferred Provider Organization (PPO). Although You may choose any medical provider or hospital, You will save money by using providers from the BlueChoice® Network.

If You choose a BlueChoice provider, the Policy will pay a greater coinsurance rate and the BlueChoice provider's rate will be based on the Allowable Amount for that provider's service. If You choose a medical provider or hospital not participating in the BlueChoice® Network, the Policy will pay a lower coinsurance rate for covered expenses and there is no Coinsurance Maximum for covered expenses from Non-Preferred Providers, including ParPlan Providers. Also, Covered Expenses of Non-Preferred Providers, paid by the Policy, will be based on the Allowable Amount, determined by the Administrator, which may be less than the provider's billed rate. The provider may bill You for the difference between the charges paid by the Policy and the provider's billed rate (balance billing). If this occurs, You will have a greater out of pocket expense. If You choose a ParPlan Provider, the Policy will pay the Non-Preferred Provider level of benefits, but the ParPlan Provider has agreed to: file Your claims; not bill You for the difference between the ParPlan Provider's charge and the Allowable Amount covered under this Policy for any treatment or services; and not bill You for treatment or services that are not Medically Necessary, as determined by the Administrator.

There are other advantages to using BlueChoice providers. They will handle the initial paperwork so You do not have to file claims. They may also precertify benefits for You, although it is ultimately Your responsibility to ensure that Your services have been authorized by the Pool.

A list of Preferred Providers in Your area is contained in the Preferred Provider Directory that was provided to You. You may call the Administrator's precertification referral department at its toll free number, 888-398-3927, to obtain the name of a Preferred Provider outside Your area, if needed. Any changes to the list of Preferred Providers will be provided to You not less than annually. You may call the Administrator during regular business hours to receive a current list of Preferred Providers. The list of Preferred Providers changes from time to time so it is important for You to verify the network status of Your providers. You can do this by confirming with Your provider that the provider is a member of the network or by calling the Administrator or checking the list of current Preferred Providers found on the Pool's web site (www.txhealthpool.org).

If there are no BlueChoice providers available to You, You must contact the Administrator's precertification referral department at its toll free number. Generally, a BlueChoice provider will be considered to be unavailable to You if You reside more than 30 miles from a BlueChoice provider. If there are no BlueChoice providers available to You and You receive approval from the Administrator before obtaining services from a Non-Preferred Provider, Covered Expenses for treatment or services by the Non-Preferred Provider will be paid at the Preferred Provider coinsurance level. If You fail to obtain approval from the Administrator prior to obtaining the services of a Non-Preferred Provider, Covered Expenses for treatment or services by that Non-Preferred Provider will be paid at the Non-Preferred Provider Coinsurance Percentage, regardless of the availability to You of a Preferred Provider.

When an Insured Person receives covered Emergency Care Services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured Person can be safely transferred to a Preferred Provider, the Insured Person must be transferred to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured Person chooses not to transfer, Policy benefits will be payable at the lower Non-Preferred Provider level.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.

If an Insured Person's Preferred Provider's arrangement with the Network, chosen by the Pool for this Policy, terminates and, at the time of such termination, the Insured Person has special circumstances, benefits for Covered Expenses received from that provider will be paid as if the Covered Expenses were received from a Preferred Provider until: in the case of an Insured Person who has been diagnosed with a terminal illness, the end of nine months after the effective date of termination; in the case of an Insured Person who, at the time of termination, is past the 24th week of pregnancy, delivery of the child, immediate post-partum care and the follow-up checkup within the first six weeks after the delivery; or in all other special circumstances, the end of 90 days after the date of termination.

"Special circumstances" means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the patient. Special circumstances must be identified by the treating Physician who must: make a request to the Administrator that the Insured Person be permitted to continue treatment under the Physician's care; and agree not to seek payment from the Insured Person for any amounts in excess of the Preferred Provider rate for the treatment or services rendered.

D. BlueCard Program

The BlueCard Program provides access to Preferred Providers of other Blue Cross and/or Blue Shield Plans outside Texas. If You incur expenses outside Texas through the BlueCard Program, You must pay the Preferred Provider Coinsurance amount, after satisfaction of the Deductible. Covered Expenses for a BlueCard program provider will be calculated using the lesser of the billed charges of the BlueCard Program provider or the negotiated rate the Administrator pays the local Blue Cross and/or Blue Shield Plan.

E. Pharmacy Benefits

The Pool offers a statewide network of pharmacies, a Mail Order program and a Specialty Medications program through WellPoint Pharmacy Management, Inc., the Pharmacy Manager. To ensure proper dosage and use, some prescription drugs may be subject to a quantity limit per prescription and/or per 30-day supply. Certain drugs will require prior authorization by the Pharmacy Manager before You can obtain a covered prescription drug at a network pharmacy. A complete list of the drugs, including growth hormone drugs and Imiglucerase, that require prior authorization can be obtained on the Pool web site, www.txhealthpool.org, or by calling the Pharmacy Manager's toll free number shown on the first page of this Outline of Coverage. Compounded drugs and branded generic drugs will be covered as brand name drugs.

1. Prescription Drug Deductible

   Benefits for outpatient prescription drugs are subject to a calendar year deductible of $100. Charges applied to this deductible or to the applicable drug copayments do not apply to the Calendar Year Deductible or to the Coinsurance Maximum amount.

2. Pharmacy Network Benefits

When Your prescriptions are filled at a network pharmacy, for up to a 30-day supply, You will pay $10 for generic drugs, or, if a generic drug is not available, $25 for formulary brand name drugs or $40 for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug copayment plus the difference in cost between the generic drug and the brand name drug.

The Pool also offers a Mail Order program through the Pharmacy Manager. When Your prescriptions are filled through the Mail Order program, for up to a 90-day supply, You will pay $25 for generic drugs, or if a generic drug is not available, $60 for formulary brand name drugs or $100 for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug copayment plus the difference in cost between the generic drug and the brand name drug.

The Pool also offers a Specialty Medications program through the Pharmacy Manager for Insured Persons who are receiving treatment for complex disease states. Specialty medications, obtained through the program, will be subject to the applicable network pharmacy copayment amount. The Pharmacy Manager will contact Insured Persons who may be eligible for this program.

3. Non-Network Pharmacy Benefits
When You fill a prescription at a non-participating pharmacy, You must pay the charges of the pharmacy and submit a claim to the Pharmacy Manager. After deduction of the applicable Copayment Amount, the Pharmacy Manager will pay a benefit equal to 90% of the lesser of the pharmacy's usual and customary charge or the amount that would have been paid by the Policy for the same prescription if dispensed by a network pharmacy. A covered prescription will not exceed a 30-day supply.

IV. Insured Person's Financial Responsibility

The Insured Person is financially responsible for: payment of premiums on a timely basis; payment to health care providers for charges that are applied to the calendar year deductible or emergency care deductible; payment to health care providers for the balance of charges after the Pool's payment of the Coinsurance Percentage; copayment amounts; balance of charges, if any, between Reasonable Charges and a Non-Preferred Provider's billed rate; any charges that are not a Covered Expenses payable under the Policy; any charges for services or treatment excluded under the Policy; and amounts in excess of benefit maximum amounts.

V. Subrogation and Reimbursement

The Policy does not pay benefits for any injury or illness for which a third party may be liable or legally responsible in contract, tort or otherwise. The Pool will advance the benefits of the Policy for such injury or illness, under the conditions outlined in the Policy. The Pool will be subrogated and/or have a right of reimbursement to all rights of recovery that You may have against such third party for charges You incurred as a result of the actions of such other party, for the amount of all benefits paid by the Pool. Your acceptance of benefits under the Policy will be deemed Your agreement and acknowledgement of the Subrogation and Reimbursement provisions of the Policy.

VI. Right to Recover an Overpayment

If the Pool makes any overpayment, the Pool can recover what it did not owe from the person to whom the payment was made or from any other appropriate person. The Pool has this right even if the mistake was the Pool's fault. If the overpayment was made to You, the Pool has the right to deduct it when the Pool pays Your claims.

VII. Exclusions and Limitations

A. Preexisting Condition Limitation:
During the first 12 months following Your effective date of coverage, the Policy will not pay benefits for any charges or expenses for a Preexisting Condition. A Preexisting Condition is a disease or condition for which medical advice, care or treatment was recommended or received during the 6 months prior to Your effective date of coverage. Preexisting Condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting Condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

The Preexisting Condition limitation will not apply to an Insured Person who:

1. has maintained Health Insurance for the 18 months immediately preceding the Insured Person's application for coverage under this Policy, excluding any waiting period, with no gap in coverage greater than 63 days, provided the most recent coverage was through an employer-sponsored plan, church plan, government plan or another state's high risk pool; or
2. was continuously covered for an aggregate period of 12 months by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period,

provided that application for coverage under this Policy is made no later than 63 days following the termination of such Creditable Coverage; or

3. who has been continuously covered, since birth, adoption or Your suit for adoption of the Insured Person, by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage.

The Preexisting Condition limitation will not apply if You are eligible for Pool coverage under the HCTC Program and You were continuously covered for an aggregate period of 3 months of Creditable Coverage that was in effect up to a date not more than 63 days before Your effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy is made no later than 63 days following the termination of such Creditable Coverage.

In determining whether the Preexisting Condition limitation applies to You, credit will be given for the time You were covered under any prior Creditable Coverage, including any waiting period for that coverage, that was in effect at any time during the 12 months before Your effective date under this Policy.

B. The Policy will not pay benefits for services or expenses or any loss resulting from or in connection with:

- Services, supplies or treatment provided: prior to the Effective Date of coverage or after the termination date of coverage for an Insured Person; or for the portion of any Hospital or other inpatient facility admission that occurs before the Effective Date of coverage or after the termination date of coverage for an Insured Person.
- Any service or supply that is not medically necessary.
- Charges for treatment, services or supplies that are Experimental or Investigational in nature.
- Any expense determined by the Pool to be in excess of the Allowable Amount.
- Any penalty or fee for the failure to keep a scheduled visit with a Physician; or any charges for completion of any insurance forms or for acquisition of medical records.
- Any charge for services or supplies that are not within the scope of authorized practice of the institution or person rendering the services or supplies.
- Any charges for physical therapy, occupational therapy or speech language therapy provided by an educational institution or school district.
- Elective procedures, treatments or medications therefor, including but not limited to, abortions, sterilization, sterilization reversals, sexual transformations, sexual dysfunctions, sexual inadequacies or disorders, or treatment for impotence.
- Any treatment provided by an Immediate Family Member of an Insured Person, except as provided for diabetes self-management training.
- Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or activity, or commission of or attempt to commit a felony.
- War or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion.
- Injury or Sickness, regardless of cause, if charges are incurred while serving in the armed forces or auxiliary units. Premium will be refunded on a pro rata basis for any Insured Person who enters military service; all coverage for that person will be suspended until military service is over.
- Any loss for which Worker's Compensation or Employer's Liability or Occupational Disease Benefits are payable.
- Cosmetic or reconstructive surgery, unless: due to an accidental injury; or reconstructive surgery following covered surgery or to repair a congenital disorder or anomaly defect of a newborn child, born to You or Your spouse after the effective date of this Policy. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a cosmetic surgery for purposes of this exclusion.
- Bariatric surgical procedures or complications related to such surgeries, even if the Insured Person has other health conditions that are related to, caused by or impacted by excess weight, obesity or morbid obesity, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- Aviation of any type, except for an air ambulance when medically necessary or as a passenger on a regularly scheduled flight on a commercial airline.
- Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.
- Care received in Veterans Administration Hospitals or facilities for a service-connected disability.
- Services or treatment provided in a government hospital unless there is a legal obligation to pay in the absence of insurance. This does not exclude coverage for the treatment of mental health and mental retardation provided by a tax supported institution of the state of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients and if benefits under this Policy would otherwise be provided.
- Services or treatment for which the Insured Person is not legally required to pay, except Medicaid.

- Personal items such as TV, admitting kits, cots for Immediate Family Members, guest meals and other items that are not Medically Necessary.
- Any dental services or supplies except as necessitated by accidental Injury. Covered Expenses must be incurred within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.
- Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting thereof, radial keratotomy or any eye surgery solely for the purpose of correcting refractive defects; treatment of myopia and other errors of refraction; orthoptics or visual training.
- Alcoholism or drug addiction.
- Any service or supply to eliminate or reduce a dependency on or addiction to tobacco or a controlled substance.
- Overdose of or illness or injury resulting from use of drugs, narcotics, hallucinogens, controlled or uncontrolled substances, unless administered on and according to the advice of a Physician.
- Illness or Injury to which a contributing cause was the Insured Person's being under the influence of or resulting from the use of intoxicants, including but not limited to, alcoholic pancreatitis, alcoholic hepatitis or alcoholic cirrhosis of the liver.
- Any service or supply associated with an autopsy or postmortem examination unless requested by Us.
- Private duty nursing services, except as provided in the Home Health Care benefit in the Benefits Provisions.
- Any service or supply in connection with the diagnosis or treatment of infertility, male or female, and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.
- Augmentation or reduction mammoplasty, except as provided for breast reconstruction in the Mastectomy benefit in the Benefits Provisions, or removal of prosthetic devices, except in the case of cancer.
- Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.
- Charges incurred in connection with a Hospital or other inpatient stay primarily for environmental change, physical therapy, custodial care or rest cures.
- Transportation, except as provided for ambulance services in the Miscellaneous Services benefit in the Benefits Provisions.
- Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to accidental Injury.
- Any service or supply received by an Insured Person as a result of or in connection with a court order, except a medical support order requiring coverage for a dependent child.
- Any service or supply in connection with routine foot care, including the removal of warts, corns or calluses, bunions, the cutting and trimming of toenails, or foot care for flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet in the absence of severe systemic disease; or any arch supports, orthopedic shoes or support hose, or similar type devices/appliances regardless of intended use, unless such use is for prevention of amputation in connection with treatment of diabetes.
- Any occupational therapy services that do not consist of traditional physical therapy modalities and that are not part of any active multi-disciplinary physical rehabilitation program designed to restore lost or impaired bodily function.
- Any medical social services or vocational counseling.
- Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- Confinement or treatment in any convalescent home, sanitarium, convalescent rest or nursing facilities or facilities primarily affording custodial or educational care or facilities for the aged, except as specifically provided in the Skilled Nursing Facility benefit in the Benefits Provisions.
- Any service or supply used for preventive care, except preventive care provided for chronic illness, cancer or HIV/AIDS or as specifically provided in the Benefits Provisions.
- Any service or supply provided for inpatient or outpatient mental health, except as specifically provided for treatment of Serious Mental Illness in the Benefits Provisions.
- Any service or supply provided for prescription drugs, except as specifically provided in the Benefits Provisions.
- Nutritional counseling or food supplements, except as provided for Home Health Care in the Benefits Provisions.
- Growth hormone drugs or treatments, except as provided in the Benefits Provisions.
- Injectable drugs or their administration for treatment of allergies.
- Any services for transplants or replacements, except as specifically provided in the Benefits Provisions.
- Genetic testing or counseling, except as provided in the Benefits Provisions, biofeedback, travel expenses, holistic therapies, acupuncture, hypnosis or massage therapy.
- Any services, supplies or medications used for the primary purpose of evaluation for or diagnosis or treatment of the condition known as Idiopathic Environmental Intolerance (IEI) or Multiple Chemical Sensitivities (MCS) or Environmental Sensitivities (ES) or any other term by which these conditions may be known.
- Charges for pregnancy or maternity care, including but not limited to normal deliveries, elective caesarean sections and elective abortions, except as provided for Complications of Pregnancy

C. In addition to those exclusions, Covered Expenses under the Prescription Drug benefit for prescription drugs will not include charges for:

- Drugs or medications that can be lawfully obtained without a Physician's prescription, except insulin and insulin analogs.
- Any charge incurred for the administration of prescription drugs by a Physician, except in connection with diabetes self-management training programs and outpatient contraceptive services.
- Drugs and substances that are Experimental or Investigational in nature.
- Drugs taken or given while an Insured Person is confined on an inpatient or outpatient basis in a Hospital, extended care facility, Skilled Nursing Home or similar institution that has a facility for providing drugs.
- Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the physician.
- Any quantity of drugs or medicines dispensed that, when taken according to the direction of the Physician, exceed a 90 day supply.
- Vitamins, prescription vitamins (except prenatal prescription vitamins), dietary supplements, cosmetic, health and beauty aids.
- Charges for drugs in excess of the Pharmacy Allowable Charges in the area where the drugs are dispensed.
- Therapeutic devices or appliances, support garments and other non-medical items regardless of their intended use, except as provided for treatment of diabetes.
- Minoxidil when prescribed for hair loss.
- Cosmetic drugs, except for acne medication, including Retin-A, Accutane, Avita and Differin, for an Insured Person under age 30 for treatment of acne vulgaris.
- Smoking cessation products.
- Blood and blood plasma.
- Appetite suppressants or any other drugs prescribed for weight loss.
- Injectable drugs for treatment of allergies.
- Infertility medications.
- Drugs or medications for treatment of sexual dysfunctions or disorders.
- Biological sera.
- Drugs or medications prescribed for an Injury or Illness arising out of employment.
- Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the insured person to pay such expenses, except Medicaid.
- Prescription Orders written by Physicians located outside the United States to be dispensed in the United States.
- Drugs or medications prescribed for treatment of Chemical Dependency.
- Drugs, including abortifacients, or devices intended to terminate a pregnancy.

V. Definitions:

Creditable Coverage means coverage provided under: a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); a group health benefit plan provided by a health insurance carrier or health maintenance organization, including a plan or policy providing coverage only for prescription drugs; an individual health insurance policy or evidence of coverage; Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1495c et seq.) (Medicare); Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) (Medicaid) other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act); a medical care program of the Indian Health Service or of a tribal organization; a state or political subdivision health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.) (Federal Employees Health Benefits Act of 1959); a public health plan as defined in federal regulations; a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); and short-term limited duration coverage (coverage provided under a contract with an Insurance Company that has a specified contract expiration date that is within 12 months of the effective date of the contract, including any extensions that may be elected by the insured without the Insurance Company's consent.

Creditable coverage does not include coverage under: accident-only, disability income insurance or a combination of accident-only and disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for onsite medical clinics; other coverage that is similar to the coverage under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; if offered separately, coverage that provides limited scope dental or vision benefits; if offered separately, long term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits or any combination of those coverages or benefits; if offered separately, coverage that provides other limited benefits specified by federal regulations; if offered as

independent, non coordinated benefits, coverage for specified disease or illness; if offered as independent, non coordinated benefits, hospital indemnity or other fixed indemnity insurance; or Medicare supplemental health insurance as defined under Section 1182(g)(1), Social Security Act (42 U.S.C Section 1395ss) (Medicare and Medicaid Patient and Program Protection Act of 1987); coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate or contract of insurance.

Dependent means a person, under age 65, described below whose name is listed in the attached application or in an endorsement to the Policy:
Your resident spouse;
Your or Your spouse's unmarried child or step-child who is under age 25;
An unmarried child adopted by You or Your spouse, including a child You or Your spouse is seeking to adopt, who is under age 25;
Your or Your spouse's unmarried grandchild who is dependent on You or Your spouse for Federal income tax purposes and under age 25 (coverage for a grandchild will not terminate solely because the Insured child is no longer Your or Your spouse's dependent for Federal income tax purposes);
A child of any age who is disabled and dependent on You or Your spouse;
An unmarried child, under age 25 for whom You or Your spouse has received a court or administrative order to provide medical support, including health insurance coverage; and
A newborn child born to You or Your spouse for the first thirty-one (31) days after birth. After thirty-one (31) days, such child will remain a Dependent under this Policy only if notice of birth is received by Us before the next premium due date, following the 31 days after birth or within the Grace Period, and the required premium, if any, is paid.

Family Member means a parent, step-parent, grandparent, brother or sister of a child who is an eligible individual, provided the Family Member resides with the child.

Health Insurance means: individual or group health insurance and includes any hospital and medical expense incurred policy, issued by an insurance company, a fraternal benefit society or a stipulated premium company; coverage provided by an approved nonprofit health corporation; a health maintenance organization subscriber contract; coverage by a group hospital service plan, or a multiple employer welfare arrangement subject to Article 3.95-1 et seq of the Texas Insurance Code; or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, including Medicaid (Title XIX of the Social Security Act). The term does not include accident, dental-only, vision-only, credit insurance or other limited benefit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance for a person under age 65, coverage by Medicare (Parts A and/or B), Medicare Supplement or Medicare Select policies, regulated in accordance with federal law, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Insurance Company means: an insurance company; a health maintenance organization; an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a group hospital service corporation; a multiple employer welfare arrangement; or any other entity providing a plan of Health Insurance or health benefits subject to state regulation.

VIII. Renewability and Termination

A. Renewal

The Policy will be renewed each time the required premium payment is made on a timely basis.

B. Termination

Coverage will terminate for each person insured under this Policy:

1. 31 days after the day on which a premium payment for the Policy becomes due if payment is not made before that date; or
2. the earlier of the premium due date or the first day of the month that follows the date on which the Pool determines:
   a. the person is no longer eligible for coverage under the Pool; or
   b. the person is no longer a resident of the state of Texas, except for: a child who is a student under the age of 25 and financially dependent upon the primary insured or his spouse; a child for whom the primary insured or his spouse is obligated to pay child support; or a child of any age who is disabled and dependent on the primary insured or his spouse; or
   c. the person is 65 years old (does not apply to an Insured Person enrolled pursuant to Section IIa. if that person is not eligible for Medicare or to an Insured Person enrolled pursuant to Section IIb. if that person is not enrolled in Medicare Part B); or
3. 30 days after the date the Pool or its Administrator makes inquiry concerning the person's place of residence or any other eligibility criteria and the person does not reply; or
4. on the first day of the month that follows the primary insured's request for termination of coverage;

5. on the date of the person's death; or
6. on the date state law requires cancellation of this Policy.

IX. Premiums

Premiums for the Pool may be paid monthly (by Automatic Bank Withdrawal), quarterly, semi-annually, or annually. Premium rates are based on Your age, gender, zip code, and tobacco use status. These rates are subject to change with at least 30 days notice. An initial premium payment equal to at least two monthly premium amounts must be submitted with an application for the Policy. A grace period of 31 days is allowed for the payment of premium, subject to the Renewability and Termination provisions above. We reserve the right to deduct the amount of any unpaid premium from any benefits paid to You or on Your behalf for charges incurred during the grace period.

X. Complaints

If You have a complaint about the Pool, please contact the Administrator at its toll free number for the procedures for filing complaints. The Pool will not retaliate against any Insured Person because a complaint is filed by or on behalf of that person.

Texas Health Insurance Risk Pool
P.O. Box 6089
Abilene, TX 79608-6089
1-888-398-3927

TEXAS Health Insurance Risk Pool

Premium Rate Tables
Effective Date 01/01/2005

Texas Health Insurance Risk Pool Premium Rate Table Instructions

Your monthly premium rate is determined by your deductible plan, age, gender, tobacco user status, and zip code.

1. Select the deductible plan you want: Plan I ($500 deductible), Plan II ($1,000 deductible), Plan III ($2,500 deductible) or Plan IV ($5,000 deductible).

   The deductible amount selected may not be changed to a lower amount after the policy is issued.

2. The rate tables are separated into tobacco user and non-tobacco user categories. You may choose the non-tobacco user category only if you have not used any tobacco products in the last 12 months.

3. Look at the table below for your zip code. The rate area is determined by the first three numbers of your zip code.

4. Find your rate area within the appropriate tobacco user status table. Next, find the age bracket that contains your age as of your anticipated coverage date. (For example, age 42 would be found in the “40-44” age bracket.) The effective date of your coverage will be the first day of the month following the date your complete application is approved, unless you request a later effective date.

5. Locate your monthly premium rate for the deductible plan you have selected. For example, a 42 year-old male non-tobacco user whose zip code begins with 754 would be located in Area 3. His monthly premium would be $599 for Plan I, $440 for Plan II, $296 for Plan III, or $237 for Plan IV.

ZIP Code Areas											
Area 1		**Area 2**						**Area 3**	**Area 4**	**Area 5**	**Area 6**
765	798	755	763	769	783	789	795	754	750	752	770
781	799	756	764	778	784	791	796	760	751	753	772
788		757	766	779	785	792	797	761	773	774	
790		758	767	780	786	793		762	776	775	
		759	768	782	787	794			777		

Administered by:

BlueCross BlueShield of Texas

Texas Health Insurance Risk Pool
P.O. Box 6089
Abilene, TX 79608-6089
1-888-398-3927

TEXAS HEALTH INSURANCE RISK POOL

Monthly Premium Rate Table

Effective Date 01/01/2005

Non-Tobacco User

	Plan I $500 Deductible		Plan II $1,000 Deductible		Plan III $2,500 Deductible		Plan IV $5,000 Deductible	
Area 1 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$296	$296	$224	$224	$152	$152	$121	$121
19-24	327	442	242	323	164	218	131	175
25-29	343	480	250	350	167	237	135	188
30-34	389	524	285	386	192	260	154	207
35-39	441	570	324	419	217	283	175	227
40-44	509	620	374	458	252	308	200	246
45-49	593	672	434	495	293	333	234	266
50-54	700	737	513	544	344	367	279	295
55-59	882	809	651	595	439	400	351	321
60-64	1,012	957	744	704	501	476	403	380

Area 2 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$334	$334	$251	$251	$170	$170	$136	$136
19-24	369	498	272	364	185	248	146	196
25-29	387	541	282	393	190	266	153	214
30-34	437	592	321	435	218	291	174	235
35-39	497	641	364	473	244	319	196	256
40-44	573	700	422	514	284	347	229	279
45-49	666	757	488	559	330	374	264	301
50-54	789	832	579	613	391	413	312	331
55-59	994	911	732	669	493	450	395	361
60-64	1,140	1,077	840	794	567	534	453	429

Area 3 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$347	$347	$263	$263	$177	$177	$142	$142
19-24	386	517	284	378	195	258	153	203
25-29	402	564	296	411	198	279	160	223
30-34	456	617	335	453	226	305	181	245
35-39	519	672	380	494	258	332	204	266
40-44	599	728	440	541	296	364	237	292
45-49	696	791	511	583	345	391	276	313
50-54	825	868	606	642	408	432	327	346
55-59	1,038	950	768	701	516	471	413	378
60-64	1,194	1,126	877	830	592	560	474	449

TEXAS HEALTH INSURANCE RISK POOL

Monthly Premium Rate Table

Effective Date 01/01/2005

Non-Tobacco User

	Plan I $500 Deductible		Plan II $1,000 Deductible		Plan III $2,500 Deductible		Plan IV $5,000 Deductible	
Area 4 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$370	$370	$280	$280	$187	$187	$151	$151
19-24	412	555	304	404	206	275	165	218
25-29	427	601	315	440	211	296	169	237
30-34	487	655	358	484	241	325	192	261
35-39	553	715	403	521	274	355	216	282
40-44	638	778	469	575	317	386	252	310
45-49	741	844	544	620	367	417	294	335
50-54	878	924	644	682	434	459	349	367
55-59	1,106	1,011	816	745	548	501	441	404
60-64	1,269	1,199	933	883	628	594	504	477

Area 5 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$391	$391	$294	$294	$198	$198	$159	$159
19-24	429	579	317	422	217	288	170	228
25-29	452	632	332	463	223	312	178	250
30-34	512	689	376	508	253	341	203	275
35-39	579	749	426	550	288	372	229	297
40-44	669	817	492	603	333	406	265	326
45-49	778	885	573	650	386	438	309	351
50-54	921	972	676	714	455	482	365	385
55-59	1,162	1,062	855	784	576	526	463	424
60-64	1,334	1,260	979	930	661	624	528	502

Area 6 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$422	$422	$316	$316	$213	$213	$170	$170
19-24	465	626	344	456	233	311	185	246
25-29	484	680	356	497	240	335	192	267
30-34	550	740	404	548	274	367	219	296
35-39	625	809	458	591	311	398	246	319
40-44	721	882	531	648	357	439	286	351
45-49	838	956	614	702	417	471	331	379
50-54	994	1,044	729	772	491	521	395	417
55-59	1,250	1,142	924	844	621	567	499	456
60-64	1,435	1,355	1,057	1,000	713	674	572	541

Texas Health Insurance Risk Pool
P.O. Box 6089
Abilene, TX 79608-6089
1-888-398-3927

TEXAS HEALTH INSURANCE RISK POOL

Monthly Premium Rate Table

Effective Date 01/01/2005

Tobacco User

	Plan I $500 Deductible		Plan II $1,000 Deductible		Plan III $2,500 Deductible		Plan IV $5,000 Deductible	
Area 1 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$386	$386	$289	$289	$191	$191	$158	$158
19-24	426	573	316	422	211	286	170	228
25-29	443	624	325	458	222	306	176	246
30-34	503	681	372	500	251	338	200	272
35-39	573	740	422	545	286	365	228	295
40-44	661	806	490	597	329	402	264	322
45-49	767	874	565	645	382	433	305	349
50-54	910	956	669	707	451	474	361	380
55-59	1,146	1,050	845	772	569	519	456	417
60-64	1,319	1,243	969	917	652	617	524	494

Area 2 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$435	$435	$327	$327	$214	$214	$177	$177
19-24	480	645	356	476	240	321	192	257
25-29	499	698	366	515	249	345	198	280
30-34	567	764	419	562	283	381	227	305
35-39	647	836	477	615	320	412	258	333
40-44	746	910	553	670	371	454	297	361
45-49	863	983	637	725	429	488	343	392
50-54	1,025	1,078	753	794	508	534	407	428
55-59	1,292	1,183	953	869	641	587	516	470
60-64	1,485	1,400	1,091	1,032	734	697	589	557

Area 3 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$453	$453	$341	$341	$226	$226	$184	$184
19-24	503	677	372	498	250	337	200	269
25-29	521	730	383	539	260	360	207	291
30-34	594	799	438	587	295	396	236	316
35-39	673	874	499	643	334	431	269	346
40-44	779	950	575	701	387	473	311	379
45-49	902	1,029	666	760	448	510	359	410
50-54	1,070	1,127	787	830	533	558	426	449
55-59	1,350	1,236	994	909	671	613	538	492
60-64	1,551	1,463	1,142	1,078	768	728	616	584

TEXAS HEALTH INSURANCE RISK POOL

Monthly Premium Rate Table

Effective Date 01/01/2005

Tobacco User

	Plan I $500 Deductible		Plan II $1,000 Deductible		Plan III $2,500 Deductible		Plan IV $5,000 Deductible	
Area 4 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$483	$483	$363	$363	$241	$241	$195	$195
19-24	532	722	393	530	265	358	213	286
25-29	556	779	407	574	276	385	219	311
30-34	633	851	465	626	313	421	251	338
35-39	718	930	529	686	356	458	286	371
40-44	827	1,011	614	746	413	502	331	404
45-49	961	1,095	709	807	477	541	382	436
50-54	1,140	1,199	839	883	564	593	453	478
55-59	1,435	1,315	1,058	970	715	651	572	524
60-64	1,651	1,559	1,213	1,148	818	774	655	619

Area 5 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$508	$508	$382	$382	$253	$253	$206	$206
19-24	561	756	415	559	280	376	226	301
25-29	585	820	429	604	290	405	231	325
30-34	666	897	491	659	328	442	265	356
35-39	756	977	557	720	373	482	299	388
40-44	870	1,063	644	783	432	530	348	422
45-49	1,010	1,150	744	848	502	570	403	458
50-54	1,196	1,259	880	928	594	624	477	501
55-59	1,509	1,381	1,113	1,018	750	684	601	548
60-64	1,734	1,636	1,275	1,205	858	812	689	651

Area 6 Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0-18	$549	$549	$410	$410	$274	$274	$221	$221
19-24	603	816	445	598	302	405	242	324
25-29	627	882	461	646	313	436	249	350
30-34	715	965	528	709	355	477	284	382
35-39	812	1,051	599	774	403	519	324	417
40-44	937	1,144	693	845	468	569	374	457
45-49	1,085	1,239	800	914	539	614	432	493
50-54	1,291	1,357	950	1,000	640	671	513	540
55-59	1,624	1,487	1,199	1,095	807	738	647	592
60-64	1,866	1,763	1,374	1,299	927	876	740	702