2015 Annual Report of the Texas Medical Association Insurance Trust

TMA INSURANCE TRUST

A Message From Bernard M. Gerber, MD

CHAIR, BOARD OF TRUSTEES

After serving on the Texas Medical Association Insurance Trust (TMAIT or the Trust) Board of Trustees for six years,

I began my term as chair on Nov. 1, 2015. In assuming the position of chair, I succeeded Robert A. Light, MD, who retired from the Board after serving for nine years and providing tremendous leadership as chair in his last year. I am honored to have the opportunity to continue the legacy of my predecessors who have so ably served since the Trust was created more than 46 years ago.

In our 2015 Annual Report, we recap the last year and look into a future in which the Affordable Care Act (ACA) continues to remain in flux more than six years after it became law.

As usual, I begin with a brief overview of the Trust's financial history before discussing the significant developments and financial results of the past year.

- Since 1969, our members have contributed **$1.66 billion** to the Trust.
- Over the past 46 years, the Trust has paid benefits or set aside as reserves for future benefit payments a total of **$1.53 billion**. This represents about **92%** of member contributions collected since the inception of the Trust.
- The Trust and its insurers have incurred net administrative expenses, taxes, and fees (administrative expenses, taxes, and fees net of investment income) of **about $64 million** since 1969. Net administrative expenses represent **3.8%** of member contributions.

The remainder of member contributions has been deposited in the Trust's Premium Stabilization Fund (PSF), which provides added security and stability for the Insurance Program.

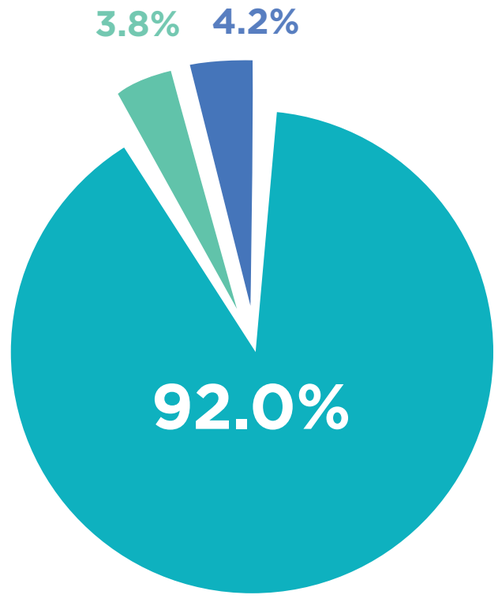
- The **$81 million** PSF has been developed from the following sources:
  - About **$69 million** in member contributions (**4.2%** of total contributions) that has not been required for benefits and administrative expenses has been deposited in the PSF.
  - In addition, the Trust deposited in the PSF about **$12 million** of after-tax proceeds from the sale of Prudential stock issued to the Trust when Prudential converted from a mutual to a stock insurer.

Helping Texas physicians so they can help others.

Exhibit 1

Uses of Member Contributions 1969 - 2015

Exhibit 1 shows the uses of member contributions to TMAIT over its 46-year history.



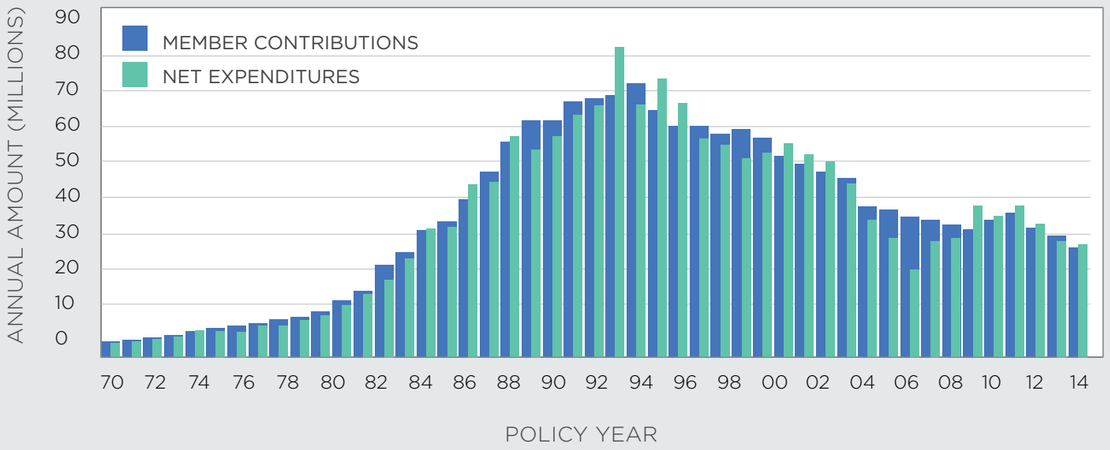
The Trustees manage Program finances in a prudent manner to achieve a balance between revenue and expenses over the long term. The Trustees believe that prudent management requires the accumulation of contingency reserves held in the PSF to secure the long-term success of the Program. In light of this, it is interesting to review Exhibit 2, which presents a historical comparison of member contributions and net expenditures on a year-by-year basis.

The Trust has enjoyed gains in many more years than it has experienced losses, with 32 years of gains and only 14 years of losses. It is worth noting, however, that the Program has shown considerable volatility, with a few years of significant losses offset by many years with considerable gains. Overall, the cumulative gains represent 4.2% of contributions over the 46-year history of the Program.

EXHIBIT 2

Comparison of Member Contributions and Net Expenditures for All TMAIT Plans Combined

Net Expenditures = Benefit Charges + Insurer-Related Expenses + TMAIT Administrative Expenses - Investment Income

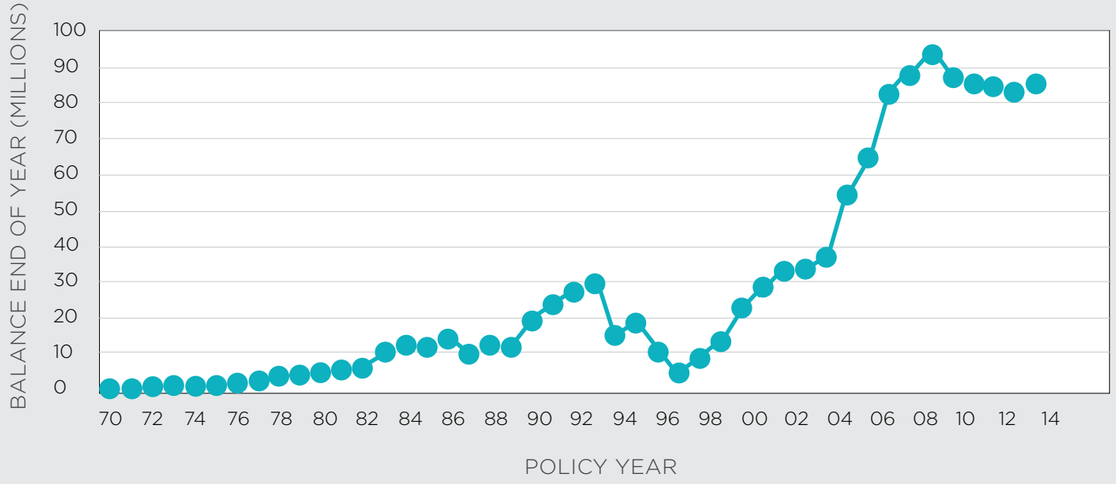


The PSF is extremely important to the success of the Program because it (1) provides security for member insurance benefits, (2) allows the Trustees to avoid immediate rate increases as a result of unexpected adverse consequences, (3) reduces the cost of insurance through moderation of risk exposure to the insurance company, and (4) provides the Program with an important source of investment income that results in lower premiums for the membership. The PSF rises and falls according to the Program's operating results.

Exhibit 3 presents the historical growth of the fund.

EXHIBIT 3

Premium Stabilization Fund Balance for All TMAIT Plans Combined



The fund enjoyed steady growth following some tough times in the mid-1990s brought on by a crisis with the long-term disability (LTD) plan.

From 1998 to 2009, the Program accumulated total gains of more than $88 million. As a result of this favorable experience, the Program's PSF increased from approximately $4 million at the end of 1997 to about $92 million at the end of 2009. The PSF has declined since 2010, primarily due to the Trustees' strategy of returning funds to the membership through reduced rates and/or enhanced benefits. This strategy includes the following initiatives.

- **Maintain health insurance rates at the lowest levels possible as long as possible.** The Trustees recognize that health insurance rate increases are unavoidable in the current environment due to the rising cost and utilization of health care services. Also, like everyone else, we dread rate increases. Not only do they cause financial difficulty for our members, but they also create a churning effect within our insurance plans as members shop for alternative coverage. Thus, it is essential that we minimize the frequency of such increases.

  In 2009, the Trustees began to utilize a strategy of deferral and minimization of health insurance rate increases, under which they have (a) deferred rate increases as long as possible and (b) consistently implemented increases that have been less-than-called-for by the actuarial rating models. This strategy, made possible by cumulative subsidies from the PSF of almost $15 million since 2008, has allowed the Trustees to establish rates over the last seven years that are about 11% lower than would have been required otherwise.

- **Reduce rates and enhance benefits in the Long-Term Disability (LTD) plan.** As a result of continued good experience, the Trustees approved a rate reduction for the LTD plan effective May 1, 2010. The reduction varied by age and averaged about 20% overall. The reduction was the fourth since 2002, with others effective Feb. 1, 2002; Aug. 1, 2005; and Feb. 1, 2007. In addition, the Trustees introduced benefit enhancements on Feb. 1, 2007; May 1, 2008; and Nov. 1, 2015. These changes reduced cost to the member while improving benefits, thus significantly increasing the plan's value to the membership.

The Trustees' strategy has resulted in a controlled reduction in the PSF over the last six years. Even with the reduction, the balance of about $81 million at the close of the 2015 policy year continues to provide a very high level of security. We'll present more information on the Program's financial condition when we discuss the 2015 operating results later in this report.

Movement of members in and out of the Trust continues to complicate the insurance pool's operation. To stabilize the insurance market for the Trust and our members, TMAIT established its own insurance agency, TMAIT Financial Services, Inc. (the Agency), in 2000 to assist those members who feel they need to shop for coverage. Through the Agency, we are able to offer a TMA member any insurance plan that is available on the open market.

Our partnership with Blue Cross and Blue Shield of Texas (BCBSTX) ... the largest health insurance carrier in the state and with whom TMA has a long-standing working relationship ... continues to ensure that the Trust can respond effectively to the membership's health insurance needs in the coming years. BCBSTX's claims management has been a major factor in the relative stability of our health insurance plans, allowing us to have only six rate increases since we joined forces 12 years ago.

Our long partnership with Prudential as the insurer of the Trust's life, office overhead, and disability plans continues to grow in strength and effectiveness, changing and evolving with the needs of the Trust and our members. Through all the years and all the challenges, our partnership has worked well in meeting our membership's insurance needs. We look forward to continuing to build on the strong and dynamic foundation we have established with Prudential over the last 46 years.

The Trustees and staff continually analyze issues and review new opportunities and concepts to maintain the Trust's leadership in providing insurance plans and services to Texas physicians. Once again, we will work especially hard during 2016, as we assist our members with the many issues that will continue to arise as we and they deal with the ongoing challenges of the ACA.

With all the uncertainties in the health care and health insurance fields, I am pleased to again report that we remain well-positioned to continue to serve the insurance needs of TMA members.

ENROLLMENT

At the end of the 2015 policy year, the insurers that the Trust and the Agency use had about 20,700 certificates of coverage in force for TMA members, their employees, and their dependents.

The Program includes 1,748 resident physicians from Texas Tech University Health Sciences Center, Methodist Hospital and Presbyterian Hospital in Dallas, and The University of Texas System Medical Foundation at Houston. By providing cost-effective insurance coverage to residents, the Trust introduces TMA and its services to a new group of young physicians. Through this service, TMAIT provides a young physician with an additional incentive to become a TMA member.

ADMINISTRATIVE COSTS

The working relationship between TMAIT and its insurers has allowed an exceptionally high return to our members over the years. As discussed earlier, the net administrative expenses (including taxes and fees) charged to the Program have averaged about 3.8% of member contributions over the history of the Program. While many insurance plans allow investment income to serve as a source of profit for the insurance carrier, TMAIT contracts require that the investment income be used to offset administrative expenses.

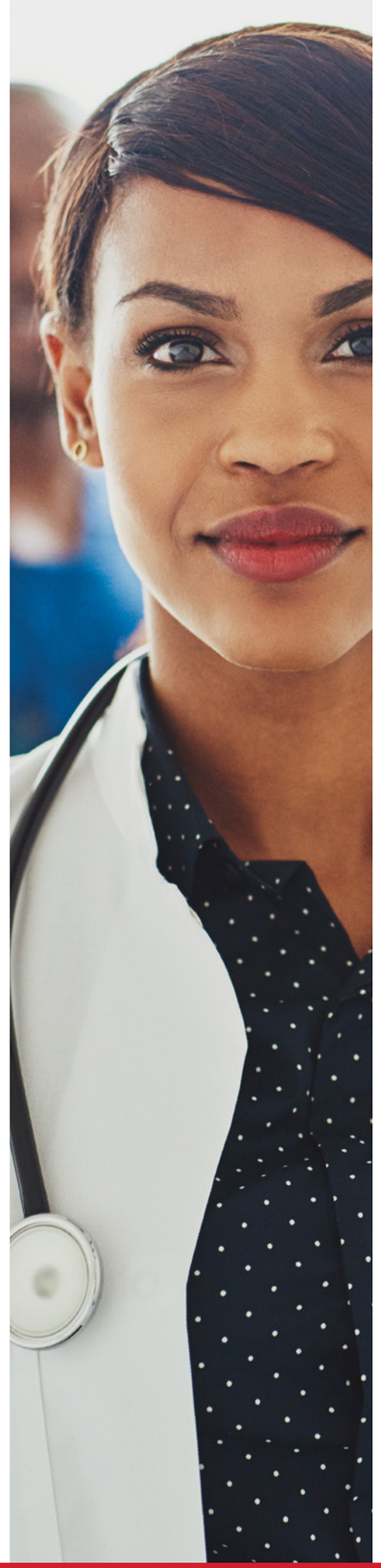
In some years, our investment income actually has exceeded our administrative expenses with the excess used to subsidize member contributions. Unfortunately, even though administrative expenses continue to be low relative to those for the typical insurance program, the economic climate has reduced our investment income significantly. In addition, the Insurance Program has been required to pay various fees related to the ACA since 2014.

For many years, the Program’s investment income increased more rapidly than its administrative expenses. Because interest rates have fallen sharply since the 2008 financial crisis, the Program’s investment income has declined significantly while administrative expenses have continued to grow through inflation and, now, through the ACA fees. This situation is likely to continue until interest rates rise.

2015 FINANCIAL RESULTS

Overall, the Program experienced an operating loss of about $1.6 million during 2015. The Program has paid out more than it took in over the last six years due to the Trustees’ strategy of returning funds to the members through reduced rates and/or enhanced benefits.

Along with our continuing effort to provide quality plans and excellent service, financial strength and stability remain TMAIT’s highest priorities. The Texas Insurance Code and prudent financial management require TMAIT and its insurers to maintain adequate funds to pay all claims incurred under the Program. These funds, referred to as “claim reserves,” are established conservatively so as to provide full assurance that all member claims will be paid when submitted. Some of these reserves are for short-term obligations, such as health claims that are submitted soon after they are incurred, while others are for payments that may not come due for many years, such as those resulting from LTD claims. At the end of the 2015 policy year, the Program maintained required claim reserves of over $38 million.



In addition to the required claim reserves, TMAIT maintains the PSF to provide further security and stability for the Program. At the end of the 2015 policy year, the Program’s PSF balance was about $81 million, equivalent to 300% of annualized Program contributions. The PSF is a major factor that distinguishes the TMAIT Insurance Program from most others.

HEALTH PLAN

Given the extent of political and media attention currently focused on health care, health insurance, and the ACA, it is impossible to pick up a newspaper or watch newscasts without seeing a report on health care and the burden it is placing on the budgets of individuals, businesses, and governments throughout the United States. The forces that drive health insurance cost —the increasing utilization and price of health care services —have continued to push per-capita TMAIT health plan cost higher over the past seven years. Overall, health plan cost has exceeded contributions by almost $15 million since 2008, primarily due to the Trustees’ strategy of deferring and minimizing rate increases while relying on the PSF to subsidize member contributions and, beginning in 2014, pay the various ACA fees imposed on the Program.

Due to the general upward trend in the cost and utilization of health care, the health plan rates were increased by an average of about 11% effective Feb. 1, 2016. The new rates reflect the following anticipated subsidies from the PSF during the 2016 policy year.

- The rates were set about 5% below the level indicated by the actuarial analysis in order to reduce the impact of the increase on the membership. This is expected to require a subsidy of about $700,000 during the policy year.
- The Board decided *not* to include in the rates a provision for the various ACA fees that will be required in the 2016 policy year. This decision is expected to require an additional subsidy of $450,000 during the policy year.

The total subsidies are expected to be almost $1.2 million in 2016. The Board concluded that such subsidies are manageable, as the health plan PSF stands at about $9 million.

While the PSF remains adequate, claims continue to increase, and the PSF continues to decline. As a result, to maintain an appropriate balance between rates and costs, we may need to raise the health plan rates again in early 2017.

The ACA will continue to present added challenges for the health plan in 2016. In addition to the cost associated with the various ACA fees, the law has prevented the Trust from adding new members to the plan after 2013. This will result in continuing reductions in plan membership, as there will no longer be new members to replace those who leave.

LIFE INSURANCE

As we discussed in the *2014 TMAIT Annual Report*, the life insurance plan experienced losses totaling almost $9 million over the period of 2008-2011. That was the only time in the history of the Trust that the life plan lost money four years in a row.

Historically, it has not been unusual for the life plan to experience volatile swings in experience. This is due to the nature of the coverage and the large amounts of

coverage in force. However, after considerable study by staff, the consulting actuary, and Prudential, the Trustees concluded that the losses experienced from 2008 through 2011 demonstrated a trend that was likely to continue unless we took action to remedy the situation.

After extensive analysis, we concluded that the plan's problems could not be solved simply through a large rate increase. Accordingly, the Trustees adopted a strategy designed to improve operating results through a combination of risk management, cost reductions, and increased revenue. The goal of this strategy is to remediate the problem in a manner that is less disruptive and ultimately more productive than a large rate increase.

Our strategy includes a revised reinsurance arrangement designed to smooth out the volatility associated with large claims, a moderate rate increase, and benefit revisions. These rate and benefit changes became effective May 1, 2012. In addition, we introduced a new life plan in 2012 in an attempt to attract new, healthy participants.

Following the changes, the plan came close to breaking even for 2012 and produced a small gain for 2013. Then, in 2014, the plan produced a gain of more than $4 million. It was the plan's best year ever. In 2014, the plan regained almost half of the cumulative amount it had lost in the previous five years.

Unfortunately, the experience for the life insurance worsened significantly in 2015 with a loss of about $700,000. The PSF balance stands at $4.6 million as of Oct. 31, 2015.

There were more death claims in 2015 (26) compared with 2014 (21) but still fewer than in 2013, when there were 30 claims. The total claim payments in 2015 were $9.9 million, which is not only significantly higher than the 2014 total ($2 million) but also even higher than the 2013 total of $8 million, the previous annual record for highest payments. The plan has now set annual claim payment records in five of the past seven years.

There were nine claims of $400,000 or more during 2015 compared with one in 2014 and nine in 2013. There were four claims of $1 million or more in 2015 (totaling $6.25 million) compared with none in 2014 and three such claims totaling $4 million in 2013.

Two of the policy changes the Board adopted in January 2012 to remediate the losses in the life insurance plan played a major role in offsetting the high claims experienced in 2015. The new reinsurance arrangement returned about $2.5 million to help offset the high death claim payments. The reinsurance arrangement will continue to help stabilize experience in the years to come. In addition, the rate increase effective May 1, 2012, continues to generate additional revenue, which also has been an important contributor to the improved overall results.

The difficulties experienced by the life plan in recent years represent a complex situation that defies a simple solution. Fortunately, the Trust is in a strong financial position to address the situation through the strategy described above. The results since implementation of the changes generally have been encouraging in spite of the loss in 2015, but it is still too early to conclude that all is well in the life plan. We expect that our strategy for the life plan is likely to require a minimum of five years to return it to a consistently self-supporting position. While we believe this approach offers a reasonable chance for improving the plan's experience over the long term, we will need to continue monitoring developments carefully and be prepared to revise the strategy if the results vary from our expectations.

OFFICE OVERHEAD

The office overhead plan experienced a gain of about $700,000 during 2015. In recognition of the strong PSF, the Trustees enhanced office overhead plan benefits effective Nov. 1, 2010. The plan's PSF balance is about $8.5 million as of Oct. 31, 2015, and remains extremely strong.

LONG-TERM DISABILITY

The LTD plan experienced a loss of $600,000 in 2015. The PSF balance for the LTD plan is almost $58.5 million.

2015 was the second consecutive year in which the LTD plan generated a loss, after 16 consecutive years of gains. This long run of favorable experience allowed the Trust to implement rate reductions effective Feb. 1, 2002; Aug. 1, 2005; Feb. 1, 2007; and May 1, 2010. In addition, benefit enhancements took effect Feb. 1, 2007; May 1, 2008; and Nov. 1, 2015.

The most recent rate reductions, which averaged about 20%, have slowed the growth of the PSF and, together with the most recent benefit enhancements will, over time, result in a decline in the fund balance. This should not present any problems for the plan given the strength of the fund.

OUTLOOK FOR 2016

Just like 2015, 2016 will be a year of uncertainty for our members due in large part to the continuing complexity and controversy surrounding the ACA. Although most provisions of the ACA have now been in effect for more than two years, federal and state governments, insurers, physicians and providers, insurance consumers, and patients continue to struggle with the aftermath. As this report goes to press, many Americans are faced with a whole new source of confusion as they deal with significant reduction in choices of plans available through the individual insurance market.

As a result, while things have changed, much has remained the same, and there continues to be a good deal of confusion in the health insurance marketplace. Therefore, a review of what has happened and what has not happened in the implementation of the ACA is, once again, in order.

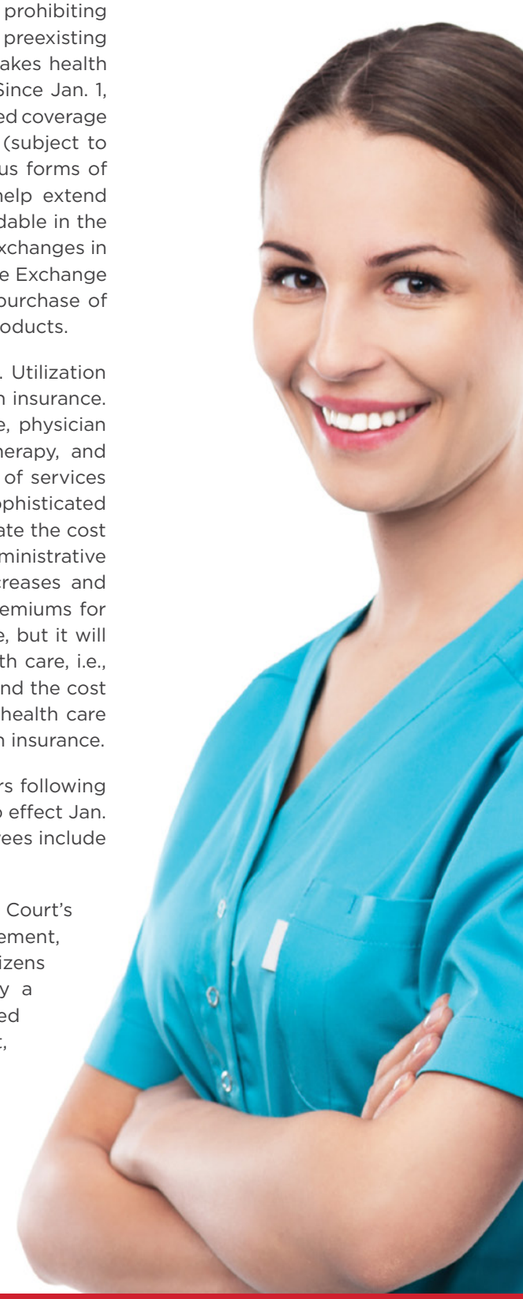
First, let's briefly review what the ACA is and is not.

- The ACA is first and foremost about **access to health insurance.** By prohibiting insurance companies from denying coverage based on a person's preexisting medical conditions, medical history, and other factors, the ACA makes health insurance accessible to all Americans regardless of health status. Since Jan. 1, 2014, except as specifically provided by law, no American can be denied coverage due to poor health. In addition, by expanding Medicaid eligibility (subject to state adoption, which did *not* occur in Texas) and providing various forms of premium and cost-sharing subsidies, the ACA will continue to help extend health insurance to individuals for whom it may have been unaffordable in the past. Finally, the ACA led to the creation of state health insurance exchanges in some states and the implementation of the Federal Health Insurance Exchange (FHIX) in the rest (including Texas). The exchanges facilitate the purchase of coverage through an online market for qualified health insurance products.

- The ACA is ***not really*** about **reducing the cost of health insurance**. Utilization and cost of health care are the primary drivers of the cost of health insurance. Americans use more health care services every year: hospital care, physician services, diagnostic lab, high-tech imaging, prescription drug therapy, and so forth. The cost of most services grows every year, and the mix of services becomes increasingly expensive with the development of new, sophisticated treatments. The ACA includes much regulation, but it will not regulate the cost of health care. The ACA will benefit consumers by moderating the administrative cost of health insurance through heightened scrutiny of rate increases and the medical loss ratio standard, which requires that 80% of the premiums for individual and small group insurance plans be spent on health care, but it will do little to reduce the portion of the premium attributable to health care, i.e., the 80% piece. The ACA creates programs that are intended to "bend the cost curve," but these programs, at best, will only slow the increase in health care cost, and, as a result, will only slow the increase in the cost of health insurance.

While various ACA provisions went into effect during the first four years following passage of the law in 2010, the ACA's most sweeping changes went into effect Jan. 1, 2014. Those with the most significance to physicians and their employees include the following.

- **The Individual Mandate.** The primary significance of the Supreme Court's landmark decision in June 2012 is its upholding of the ACA requirement, commonly referred to as the individual mandate, that most U.S. citizens and legal residents maintain qualifying health insurance or pay a penalty. The annual penalty, which phases in over three years, is based on a flat dollar amount ($95/adult, $47.50/child in 2014; $325/adult, $162.50/child in 2015; and $695/adult; $347.50/child in 2016) with a family cap of the greater of (a) three times the adult rate or (b) a percentage of household income (1% in 2014, 2% in 2015, and 2.5% in 2016 and later). The flat dollar amounts will be indexed for years after 2016. While attempts to eliminate the individual mandate continue, it remains in effect at this time.



- **Health Insurance Exchanges.** The ACA provides for the creation of state-based health insurance exchanges to be administered by a government agency or nonprofit organization. The state-based exchange is intended to serve as a market clearinghouse for qualifying health insurance coverage for individuals and small businesses with 100 or fewer employees. The ACA authorizes each state to create its own state exchange; however, it authorizes the U.S. Department of Health and Human Services (HHS) to operate the FHIX in a state like Texas that chooses not to establish its own exchange. Although the FHIX got off to a slow and rocky start in its first year of operation (2014), it has seemed to work much more smoothly in 2015 and 2016. Open enrollment for 2016 coverage through the FHIX ran from Nov. 1, 2015, through Jan. 31, 2016. The open enrollment period for 2017 will run from Nov. 1, 2016, through Jan. 31, 2017. Failure to enroll during this period will prevent enrollment in qualified health insurance for 2017 unless the applicant qualifies for a Special Enrollment Period by reason of a "life event."

- **Health Insurance Premium and Cost-Sharing Subsidies.** Sliding-scale premium subsidies are available to individuals and families with a household income of 100-400% of the federal poverty level (FPL) to purchase individual insurance through the state exchanges and the FHIX. Sliding-scale cost-sharing subsidies (assistance in paying deductibles, coinsurance, and copayments) also will be available to those with household incomes up to 250% of FPL. The 2015 FPL ($11,770 for an individual and $24,250 for a family of four) will be used in determining eligibility for premium subsidies in 2016. HHS revises the FPL annually, usually in late January.

- **Guaranteed Availability of Health Insurance.** The ACA requires guaranteed issue and renewability of health insurance purchased through the state exchanges, the FHIX, and the individual and small group markets. In addition, rates may vary only by age, geographic area, family composition, and tobacco use. Rates for the oldest age category cannot exceed those for the youngest age category by more than a 3:1 ratio. Rates for tobacco users cannot exceed rates for non-users by more than 50%.

- **Employer Requirements.** Employers *with 50 or more employees* that do not offer health insurance and have at least one full-time employee (FTE) who receives a premium subsidy for insurance purchased through a state exchange or the FHIX will be subject to an annual penalty of $2,000 for each FTE in excess of 30. Employers *with 50 or more employees* that offer health insurance but have at least one FTE who receives a premium subsidy will be subject to an annual penalty equal to the lesser of (a) $3,000 for each employee receiving a subsidy or (b) $2,000 for each FTE in excess of 30. These amounts are prorated based on the number of months that an employee does not have coverage and will be indexed for years after 2015. These requirements, which originally were intended to go into effect in 2014, were delayed until 2016 for employers with 50-99 employees; the requirements were delayed until 2015 and softened somewhat for employers with 100 or more employees. *Employers with fewer than 50 employees will not be subject to penalties for (a) failing to provide health insurance or (b) having employees who receive subsidies through the state exchanges or the FHIX.*

- **Essential Health Benefits.** The ACA requires that health insurance offered to individuals and small businesses cover a comprehensive list of health care services while limiting out-of-pocket cost in 2016 to $6,850 for an individual and $13,700 for a family. Under the ACA, the limits are indexed annually. A health insurance plan must fall into one of four "metallic" categories based on the proportion of the full actuarial value of the essential health benefits it covers (bronze=60%, silver=70%, gold=80%, or platinum=90%). These requirements apply to plans in and out of the exchanges.

- **ACA Fees on Insurance Programs.** The ACA imposes three separate fees on insurance providers and the plans they cover.

  - The Transitional Reinsurance Program (TRP) is a complex risk assessment system created by the ACA. TRP includes a temporary fee (2014-2016) that generates funds intended to help stabilize the premiums in the individual market. The majority of group health plans, both fully insured and self-funded, are responsible for funding the program through an assessment via their health insurer or third-party administrator.

  - The ACA established a Patient-Centered Outcomes Research Institute, which is charged with identifying the effectiveness of various forms of medical treatment. The Comparative Effectiveness Research Fee is another temporary fee (2012-2019) imposed on insurers and self-funded plans. The monies collected from the fee are used to fund research on the effectiveness of medical treatments and prescription drugs.

  - The Health Insurance Providers Fee (HIP Fee) is assessed against each insurance company based on its proportionate share of total premiums written in the national insurance market. This fee, which was first assessed for 2014, is permanent and is intended to help fund the additional cost associated with the ACA. The Consolidated Appropriations Act of 2016 suspends collection of the HIP Fee for 2017. This suspension should provide a one-time savings for consumers by cutting insurer costs during that year.

Even as implementation of the ACA proceeds, a variety of forces continue to threaten the long-time survival of the law.

- **Litigation.** Many cases challenging the constitutionality of various ACA provisions have been litigated since the passage of the law. One of the most significant of these was resolved in 2015 in the Supreme Court's decision in *King v. Burwell*. The plaintiffs in this case argued that federal subsidies to support the purchase of qualified health insurance through the exchanges are available only when the state, not the federal government, creates the exchange. Many states, including Texas, have not created a state exchange. Therefore, this challenge, if successful, would have had far-reaching effects, since it would have eliminated subsidies for those purchasing coverage through the FHIX, which in turn would have led to the cancellation of coverage for many who could not afford to purchase coverage on their own. In a 6-3 ruling, the Court rejected the plaintiff's arguments in finding that that Congress intended to provide tax credits to subsidize health insurance premiums for consumers equally in each state no matter whether the state or the federal government established the exchange.

  But the decision has not ended litigation challenging the ACA. The most significant of the cases currently making their way through the judicial system is *U.S. House of Representatives v. Burwell*. The case alleges that the administration is illegally spending money that Congress never appropriated for the ACA's cost-sharing reductions. Under the ACA, insurers provide reduced deductibles, copayments, and coinsurance for qualifying individuals who purchase coverage through the exchanges. Individuals qualify for the cost-sharing reductions based on income. The federal government reimburses the insurers for cost-sharing reductions they provide.

  If the House prevails in this case, several of the costs to the federal government could increase significantly because the ACA requires insurers to offer cost-sharing reductions regardless of the availability of government funding.

  - Without government reimbursement, insurers may offset those losses by increasing premiums on plans offered through the exchanges.

  - That, in turn, would cause premium tax credits to rise to cover the higher premiums.

  - The government would then be required to fund higher premium tax credits, which would go to many more people than just those who receive cost-sharing reductions.

  It's also possible insurers would sue the federal government for the reimbursements, arguing the government is obligated to provide them. Or, insurers may simply drop out of the exchanges, frustrated by the seemingly endless litigation against the law and the uncertainty it creates. In summary, the market could be thrown into a new state of havoc if the House prevails in this case.

- **Congress.** Since passage of the ACA in 2010, there had been numerous attempts to repeal the ACA even before the Republicans took control of both houses of Congress in January 2014. Since then, these attempts have intensified. The movement to repeal reached a new level in January 2016 when Congress passed and sent to the President a bill that would have repealed the ACA. As expected, the President vetoed the bill, which then went back to Congress, which did not have the votes to override the veto. Although the bill is dead for now, it is significant because it marks the first time Republicans have been able to send repeal legislation to the President, after more than 60 votes to roll back all or part of the law. With all remaining Republican presidential candidates pledging to repeal the ACA if elected, it is clear that such legislation would be a high priority early in the term of a newly elected Republican president.

- **Reduction in Plan Choices.** Most major health insurers have suffered significant losses on coverage written in the individual insurance market, both on and off the exchanges. These losses have resulted in large part from the adverse selection inherent in guaranteed issue coverage as required under the ACA. The immediate impact of the losses has been a significant decline in the number and types of individual health insurance plans available both on and off the ACA exchanges. Longer term, continued losses could lead to insurers leaving the market, which could undermine the primary goal of the law: providing access to affordable coverage through the private sector. No doubt this would set off a whole new debate about the best way to provide health coverage to Americans.

Now, let's take a look at what this all means to TMAIT and its members.

First, the ACA applies only to health insurance plans. As a result, *it has no effect whatsoever on the TMAIT life, office overhead, and disability plans.*

While the ACA impacts health insurance plans, the TMAIT health plan is a "grandfathered health plan" under the ACA. While we have made some relatively minor changes that apply to grandfathered as well as non-grandfathered plans, some of the changes described above do not apply to the TMAIT health plan. As a result, there have been no significant changes; i.e., TMAIT health plan members continue to receive the same coverage they have in the past. Part of this "sameness," however, means that TMAIT health plan premiums will continue to rise periodically in the future as they have in the past. As we said before, the ACA has not changed anything that drives the factors that influence the cost of health insurance. Unfortunately, the TMAIT health plan has been and will continue to be adversely impacted by ACA-imposed fees assessed against all health insurance plans.

Please note, however, that the grandfathered status applies only to the TMAIT health plan; it does not apply to the individual and small group health plans that many of you have purchased through the Agency. All such plans must comply with all provisions of the ACA, including those described above.

While it is our intent to maintain the grandfathered status of the TMAIT health plan as long as possible, the health insurance market and regulatory environment are rapidly changing, and we cannot predict the full impact of these changes on our plan and our insurance partner, BCBSTX, over the long term. Our membership can be certain, however, that the Trustees and staff will continue to stay on top of the market and will be available to help our members as they chart the course that is best for them.

The Trust remains the best source for reliable assistance in the health insurance marketplace for some very important reasons.

- Through TMAIT and the Agency, TMA members have access to every insurance product in today's market in addition to the valuable Trust plans available only to TMA members. The ACA has not impacted our ability to assist our members in shopping for health insurance. In fact, we help members who are shopping both in and out of the FHIX. We know there is much confusion, and our goal is to help clarify this challenging situation so that our members can make decisions that are best for them.
- TMAIT Trustees and staff know and understand physicians better than anyone in the insurance market. We exist only to serve physicians. As a result, our service is unparalleled.
- TMAIT works closely with TMA to support its members and programs.
- TMAIT is governed by Trustees who are appointed by TMA or elected by the TMAIT membership.

In 2015, we launched several initiatives to improve services to our members.

- **On-Line Shopping.** The implementation of public federal and state health insurance exchanges under the ACA has encouraged the development of Private Insurance Exchanges (PIX). Like public exchanges, a PIX is an online tool that facilitates insurance marketing, purchasing, application, enrollment, and administration. Unlike the public exchanges, a PIX can be used for all lines of insurance rather than just health insurance.

  TMAIT staff and our consultants engaged in a major initiative in 2014 to identify and evaluate various PIX software platforms to determine their potential for meeting the needs of our members in the insurance market of the future. During the 2016 open enrollment period, we had online shopping capabilities for health, dental, and life insurance. We are working to add online shopping for disability, office overhead, critical illness, and other ancillary products.

- **Customer Relationship Management (CRM).** After considerable research by TMAIT staff and our consultants, we have implemented a CRM platform that will enable TMAIT to better serve TMA members. Our new platform automates sales and service processes for all individual coverages. The CRM platform simplifies management processes by housing all member data, storing and retrieving all related information in a document management system, creating electronic workflows to move member data through the organization more efficiently, and integrating new processes with existing and planned marketing activities. Our cloud-based system in which we enter new-customer information and update communications with existing customers provides our entire staff real-time access to an up-to-date snapshot of customer information. We are in the early stages of establishing technology and operational procedures that will help us maintain our competitive edge in the physician insurance market. During 2016, we plan to enhance our tracking and reporting capabilities with the CRM.

- **Marketing.** The increasing popularity of digital services in the insurance marketplace is creating interesting challenges and opportunities for old and new competitors. Insurance companies and agencies are seeking to gain a market edge by instituting technology-driven business and marketing processes.

  TMAIT staff and our consultants have conducted a thorough study of our current marketing capabilities to determine how we can update and improve them to meet our organizational goals, both in the near and long term. Based on that study, we engaged a new digital marketing partner to assist us in our digital marketing efforts including social media, web properties, mobile applications, and email. Our partner also will provide us sales and marketing content for our website, publications, brochures, and email campaigns.

  In 2015, we also introduced new branding, a redesigned website, a blog that contains educational articles on various insurance topics, a monthly newsletter, and social media promotion.

- **New Products/Enhancements.** We continue to improve and expand our coverage options for physicians.
  - In May 2015, we added a new vision plan.
  - Effective Nov. 1, 2015, we made a number of enhancements to the LTD Plan:
    - Increased the specialty occupation (Own Occ) period from five to seven years.
    - Liberalized the partial disability benefit.
    - Increased the mental and nervous limitation from two to three years.
    - Liberalized age reductions: from $2,000 at age 65 to $5,000 at age 65; from $400 at age 70 to $2,000 at age 70; term at age 75.
    - Eliminated the third-party offset.
    - Increased the available monthly maximum for the 90-day elimination period option to $15,000 subject to a 12/12 pre-existing condition limitation.
    - Increased the available monthly maximum for the 30-day elimination period option to $10,000, subject to a 12/12 pre-existing condition limitation.
  - We also enhanced the Office Overhead plan effective Nov. 1, 2015 as follows:

    Raised the maximum monthly benefit from $35,000 to $50,000.

    Revised the wording to permit benefit payments to be paid to the physician's office (as opposed to just the claimant).
  - We plan to add personal auto, homeowners and umbrella policies to our portfolio in 2016.

- **Individual Health Insurance Market.** During the month of August 2015, BCBSTX announced that it would no longer offer its Blue Choice PPO in Texas because it was no longer sustainable at the cost at which it was being offered. As a result of this announcement, TMAIT made efforts to inform all TMA members of this significant change. We emailed notifications to four distinct groups: (1) TMA members who are not currently insured by TMAIT, (2) TMAIT insureds who are non-BCBSTX policyholders, (3) TMAIT-unaffected BCBSTX policyholders, and (4) TMAIT-affected BCBSTX policyholders.

  The staff then followed up during the 2016 open enrollment period, working with each member to replace coverage with the best available plan for that member. Understandably, many members were disappointed with their options but grateful to the staff for their diligent assistance in locating alternative coverage.

Despite the many challenges and changes that have occurred in the past 10 years in the association insurance market, in the medical profession, and with health insurance as a result of the ACA, the package of products TMAIT provides its membership continues to grow in value. Our relationship with BCBSTX and the availability of the Agency allow us to offer the most extensive range of health insurance products which has improved the viability of all the plans. At the same time, our other insurance and financial products continue to give physicians a wide range of choices — from life and disability insurance to long-term care products.

We expect 2016 to present many of the same challenges that we have been dealing with in recent years: a volatile economy; changes in the delivery of health care; strained federal and state budgets; and ACA-generated rules, regulations, and changes in insurance markets.

We are continuously engaged in the evaluation of new coverages and services that could be valuable to our members. We are presently pursuing several possibilities that we could add to our portfolio later this year pending completion of a thorough due diligence process.

In these confusing times, our members will look to the Trust and the Agency more than ever to help them maximize stability and security in their insurance portfolio in the most cost-effective manner. While it is impossible to predict the impact the continuing evolution in health care and health insurance may have on the Trust and its products, our members can be confident that the Board, our staff, and our advisors will monitor the situation carefully and will be prepared to act in the best interest of the membership by providing them the best products and services available in the market.

The Board of Trustees understands that we can accomplish our objectives and maximize our service to the membership only through the well-trained and dedicated staff we have developed over the years. We and the staff are committed to providing high-quality, cost-effective service and products to TMA members. The Trust, with its financial strength, wide array of insurance products, and commitment to meeting the needs of our members, will continue to provide a reliable source of insurance coverage for TMA members in the years to come.

TRUSTEES

TMAIT operates under the authority of an eight-member board. During 2015, the Trustees met in person in January, April, and September in conjunction with TMA conferences and the House of Delegates meeting. In addition, the Trustees held their annual three-day planning session in July.

ADVISORY COMMITTEE

The Board of Trustees is assisted by the TMAIT Advisory Committee, composed of nine TMA physicians and a TMA Alliance member appointed by the Trustees for the purpose of reviewing claims and underwriting decisions appealed by the membership. The Advisory Committee, which includes a variety of medical specialists, provides a member the opportunity for a panel of his or her peers to review insurance carrier decisions concerning underwriting and claim matters. The Advisory Committee is one of the principal strengths of TMAIT, as it gives each member a forum for further consideration of decisions that affect insurance coverage.

STAFF

To further enhance member services, TMAIT maintains a 21-person staff at TMA's Austin headquarters. TMAIT staff are involved in every phase of the Program, from enrollment and billing to claims assistance. With direct access to all membership information, TMAIT staff can supply an immediate response to a member's inquiry about insurance benefits. Staff are assisted by actuarial, legal, financial, tax, and technology advisors who offer advice on a broad range of technical issues. Staff serve as a liaison between the membership and the insurance carriers, and provide a member service that generally is not available to an individual purchasing coverage through the commercial insurance market.

Through the combined resources of TMAIT and the Agency, we are able to offer TMA members access to an extremely broad range of insurance products from the cost-effective group insurance plans offered through the Trust to individual insurance products tailored to specific needs.

OUR INSURERS

The TMAIT life, office overhead, and LTD plans are underwritten by Prudential Insurance Company of America, Prudential Plaza, Newark, NJ 07102. The health insurance plans are underwritten by Blue Cross and Blue Shield of Texas, Dallas, TX 75265. In addition to providing financial security, the insurers are important members of the TMAIT administrative team. Working in partnership with the Trustees, the Advisory Committee, and TMAIT staff, the insurers provide TMAIT the high level of insurance expertise and administrative assistance required to operate a cost-effective, state-of-the-art insurance program successfully. TMAIT staff communicate throughout each day with our insurance representatives; this close contact allows TMAIT to provide first-class service to its membership.

TMAIT BOARD OF TRUSTEES

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TMAIT STATISTICS FOR 2015 ANNUAL REPORT

BENEFIT PAYMENTS

PLAN	2015 BENEFIT PAYMENTS *(Millions)*
HEALTH	$11.8
LONG-TERM DISABILITY	6.4
LIFE	9.9
OFFICE OVERHEAD	0.6

MISCELLANEOUS

Total Contributions:
$26.9M

Combined Premium Stabilization Fund:
$80.5M

2015 ENROLLMENT BY PLAN

PLAN	ENROLLMENT
LIFE INSURANCE	3,926
LONG-TERM DISABILITY	3,863
OFFICE OVERHEAD	865
PERSONAL ACCIDENT	1,732
HEALTH	1,861
DENTAL	825
VISION	31

2015 PROGRAM HIGHLIGHTS

Rate of Return on Invested Assets
3.0%

LTD Payments
1,454

Disabled Physicians Receiving LTD Payments
104

New LTD Claims
7

Death Claims
26

Applications
821

Coverage Quotes
1,498

Billings
31,817


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