TEXAS MEDICAL ASSOCIATION INSURANCE TRUST

2013 Annual Report

Helping Texas physicians so they can help others

Texas Medical Association Insurance Trust

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A MESSAGE FROM KEVIN P. MAGEE, MD
CHAIR, BOARD OF TRUSTEES

2013 was an extremely interesting and challenging year for the Texas Medical Association Insurance Trust (TMAIT or the Trust), as it was for all insurance organizations in the United States. As I indicated in the 2012 Annual Report, 2013 truly was the "end of the beginning" of a new era of health care reform. With most of the remaining requirements of the Affordable Care Act (ACA) going into effect on Jan. 1, 2014, we have finally reached the "beginning of the beginning" of this new era with all of the attendant confusion, problems, changes, and opportunities.

At the end of 2013, we said goodbye to a great leader and friend, Larry Stein, who retired after serving as the Trust's Administrator since 1985 and as the President of the Trust's wholly-owned insurance agency, TMAIT Financial Services, Inc. (the Agency), since its inception in 2000. The Trust, the Agency, and their membership grew and prospered under Larry's leadership. We are grateful for Larry's many years of service, and we wish him well as he enters the next phase of his life.

Among the many achievements of Larry's career was the recruitment and mentoring of James Prescott, who the Board of Trustees named to replace Larry as Administrator of TMAIT and President of the Agency effective Jan. 1, 2014. James joined the Trust in 1991 as Director of Marketing. He was later promoted to Associate Administrator with responsibility for both marketing and operations. He became Secretary/Treasurer of the Agency in 2000 and continued in both roles through 2013. James has extensive experience in all aspects of insurance marketing and operations, and has spent the last 23 years working with physicians, medical practices, and resident facilities throughout the state. The Board is extremely pleased to have such an experienced and capable leader to replace Larry.

In our 2013 Annual Report, we recap the last year and look into a future in which the ACA is reality.

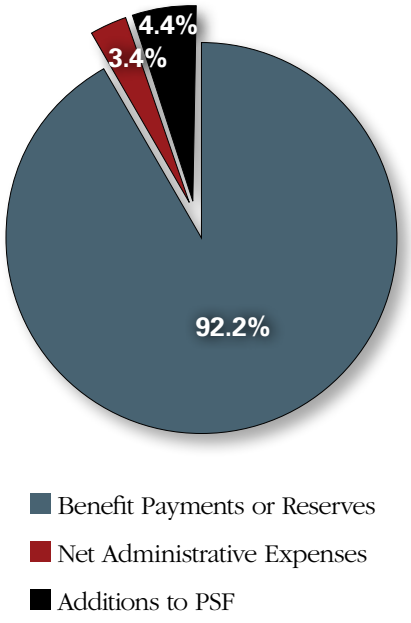
As usual, I begin with a brief overview of the Trust's financial history before discussing the significant developments and financial results of the past year.

- Since 1969, our members have contributed **$1.61 billion** to the Trust.
- Over the last 44 years, the Trust has paid benefits or set aside as reserves for future benefit payments a total of **$1.48 billion**. This represents about **92.2%** of member contributions collected since the inception of the Trust.
- The Trust and its insurers have incurred net administrative expenses (administrative expenses net of investment income) of about **$54 million** since 1969. Net administrative expenses represent **3.4%** 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 **$84 million** PSF has been developed from the following sources:
  - About **$70 million** in member contributions (**4.4%** 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 **$14 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.

Exhibit 1 shows the uses of member contributions to TMAIT over its 44-year history.

Exhibit 1

Uses of Member Contributions 1969-2013



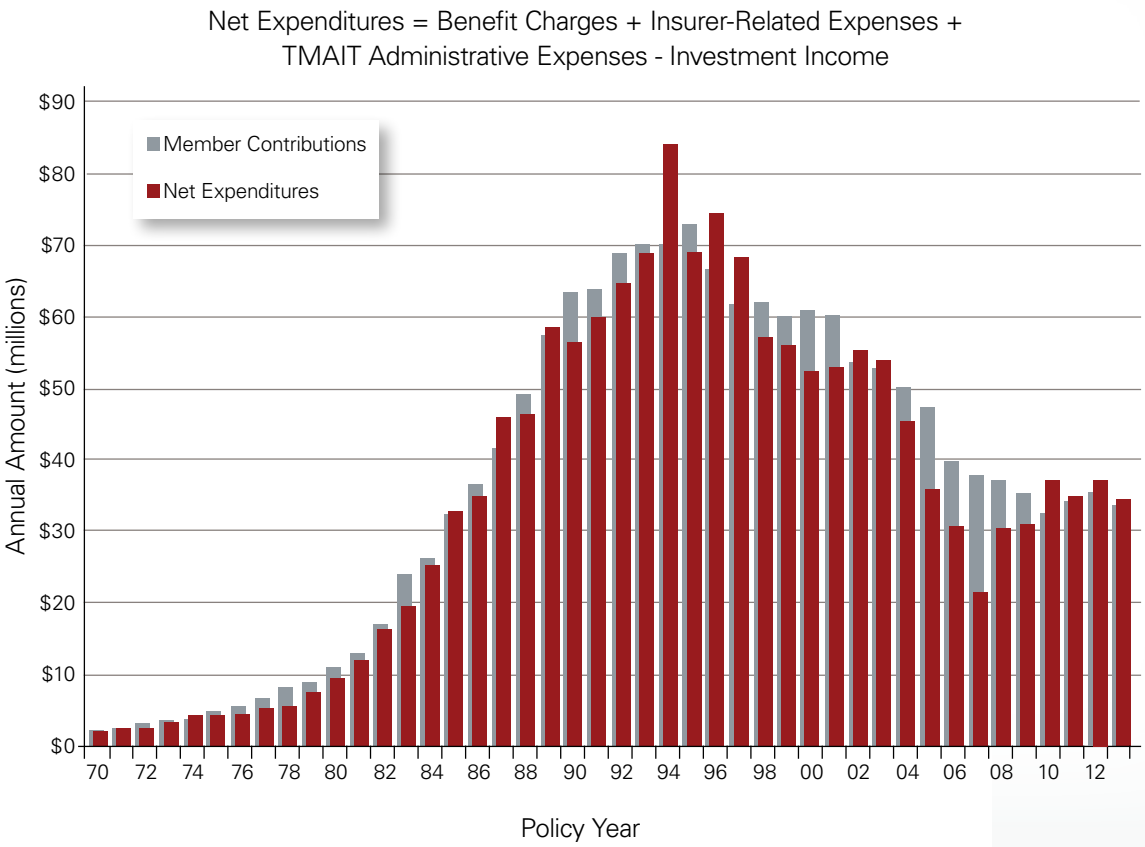
The Trustees manage Program finances in a prudent manner to achieve a balance between revenue and expenses over the long term. The Trustees believe that prudent management requires the accumulation of contingency reserves held in the PSF to secure the long-term success of the Program. In light of this, 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 31 years of gains and only 13 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 4.4% of contributions over the 44-year history of the Program.

"The Trust has enjoyed gains in many more years than it has experienced losses, with 31 years of gains and only 13 years of losses."

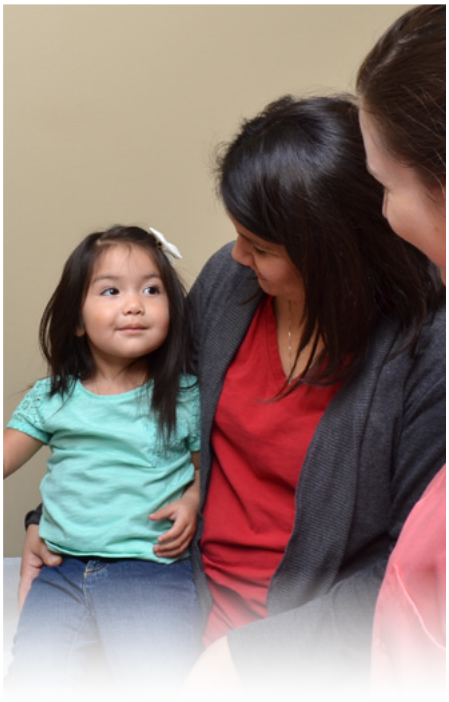
Exhibit 2

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



The PSF is extremely important to the success of the Program as 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 on the next page presents the historical growth of the fund.



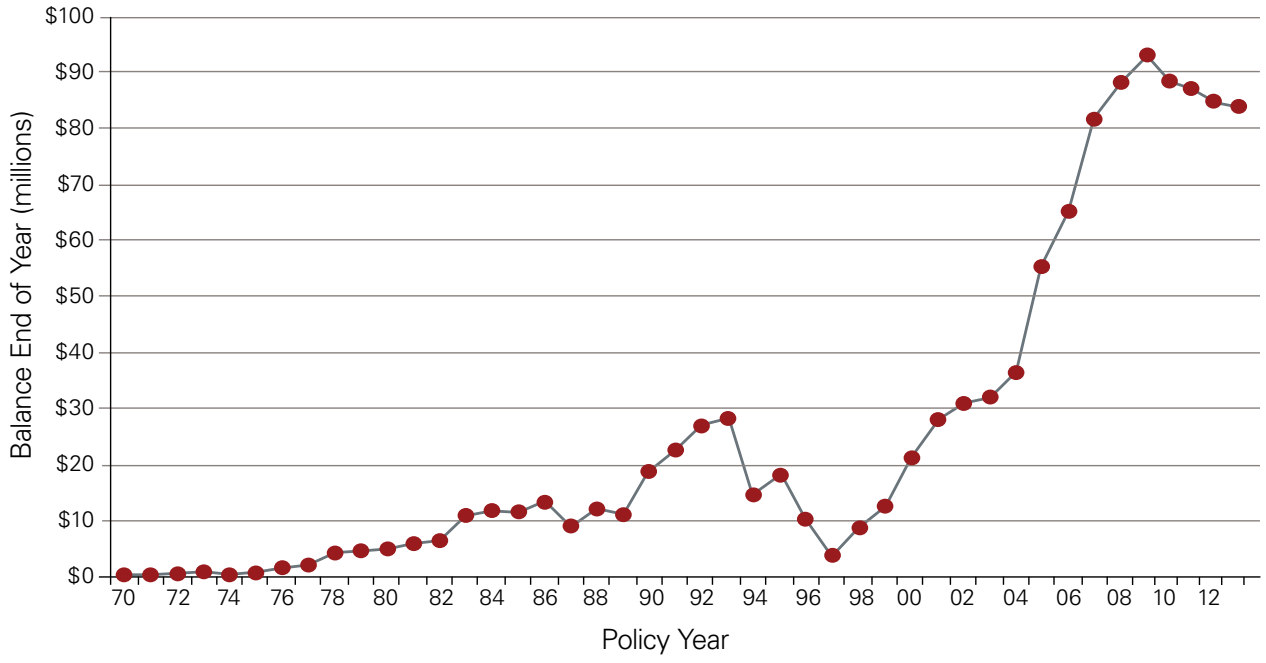
After some tough times in the mid-1990s that were brought on by a crisis with the long-term disability (LTD) plan, the fund enjoyed steady growth. From 1998 to 2009, the Program accumulated total gains of more than $88 million. As a result of this favorable experience, the Program's PSF increased from approximately $4 million at the end of 1997 to about $92 million at the end of 2009. The PSF has declined somewhat over the last four years in part due to continuation of 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.** Maintaining adequate health insurance rates is an ongoing challenge. Like all health plan sponsors, 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.

  Since 2009, the Trustees have utilized 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 a subsidy of almost $12 million from the PSF, has allowed the Trustees to establish rates over the last five years that are over 11% lower than would have otherwise been required.

Exhibit 3

TMAIT Premium Stabilization Fund Balance for All Plans Combined



- **Reduce rates and enhance benefits in the 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, benefit enhancements were implemented Feb. 1, 2007, and May 1, 2008. The cumulative impact of these changes reduced plan revenue and increased plan cost while increasing value to the membership.

The losses experienced by the Program over the last four years have reduced the PSF to about $84 million, an amount that continues to provide a very high level of security.

We'll have more information on the Program's financial condition when we discuss the 2013 operating results later in this report.

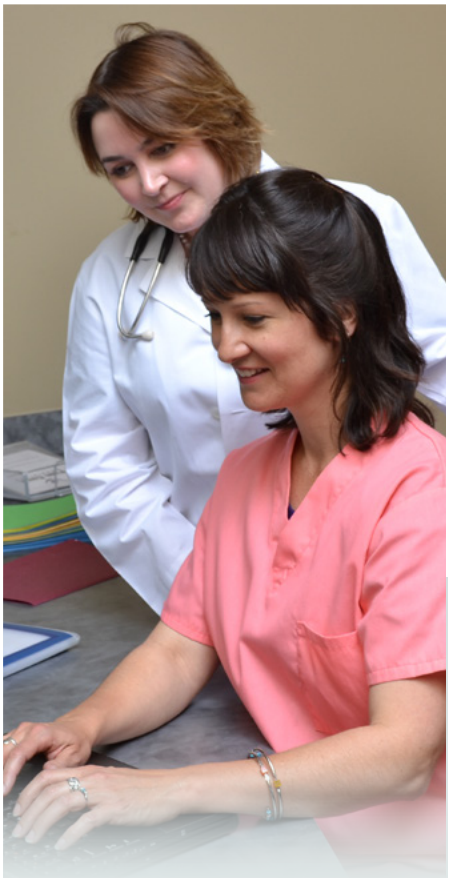
Movement of members in and out of the Trust continues to complicate the insurance pool's operation. To stabilize the insurance market for the Trust and our members, TMAIT established the Agency in 2000 to assist those members who feel they need to shop for coverage. Through the Agency, we are able to offer a TMA member any insurance plan that is available on the open market. At the end of 2013, the Agency was providing coverage for about 8,476 TMA members, employees, and dependents.

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 maximize its responsiveness 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 as well as allowing us to have only four rate increases since we joined forces 10 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 44 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. We will continue to work especially hard during 2014 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 2013 policy year, the insurers employed by the Trust and the Agency had more than 23,000 certificates of coverage in force for TMA members, their employees, and their dependents.

The Program includes 1,500 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 charged to the Program have averaged about 3.4% 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 a number of years past, our investment income actually 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. As a result, net administrative expenses for 2013 were about 11.4% of member contributions, slightly higher than the 10.7% rate experienced in 2012. Although this level is high compared with the historical average for the Trust, it is significantly below rates prevalent in the insurance industry.

For many years, the Program's investment income increased more rapidly than its administrative expenses. Since interest rates began to fall sharply in response to the 2008 financial crisis, the Program's investment income has declined significantly while administrative expenses have continued to grow through inflation. This situation is likely to continue until interest rates rise.

2013 Financial Results

Overall, the Program experienced an operating loss of about $750,000 during 2013. This was the fourth consecutive year that the Program has paid out more than it took in. As discussed above, these results were not unexpected given 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 2013 policy year, the Program maintained required claim reserves of almost $42 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 2013 policy year, the Program's PSF balance was about $84 million, equivalent to over 250% of annualized Program contributions. The PSF is a major factor that distinguishes the TMAIT Insurance Program from most others.

"Along with our continuing effort to provide quality plans and excellent service, financial strength and stability remain TMAIT's highest priorities."

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 — pushed TMAIT health plan cost above the contributions paid by members during each of the last five years. Overall, the health plan produced a cumulative loss of almost $12 million over that period.

The health plan continued to generate a loss during 2013 due to the combined effect of (a) claims experience that was somewhat worse than expected, (b) member contribution rates that were intentionally set below the level required to break even, and (c) the extension of those rates for an additional quarter as we and BCBSTX continued to sort through various issues related to compliance with the ACA.

Due to the continuing loss and general upward trend in the cost and utilization of health care, the health plan rates were increased by an average of 16% effective November 2013. The new rates reflect the following anticipated subsidies from the PSF during the 2014 policy year.

- The rates were set about 4% below the level indicated by the actuarial analysis 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 2014 policy year. This decision is expected to require an additional subsidy of $800,000 during the policy year.

The total subsidies are expected to be about $1.5 million in 2014. The Board concluded that such subsidies are manageable, as the health plan PSF stands at about $12 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 will probably need to raise the health plan rates later in 2014.

The ACA will continue to present added challenges for the health plan in 2014. In addition to the various fees that will increase cost, the law prevents adding new members to the plan in 2014 and subsequent years. This will result in continuing reductions in plan membership, as there will no longer be new members to replace those who leave.

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Life Insurance

As previously reported, the life insurance plan experienced losses totaling almost $9 million over the period 2008-11. 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 achieve improvement in 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, a new life plan was introduced in 2012 in an attempt to attract new, healthy participants.

After coming close to breaking even for 2012, the life plan produced a small gain for 2013, the plan's best year since 2007. Ironically, there were more death claims in 2013 (30) as compared to 2012 (23), and the total payments ($8 million) were almost $5 million higher than in 2012 ($3.2 million). The 2013 death claim payments set a new annual record for highest payments, exceeding the previous record of $7.1 million established in 2011. The plan has now set records in four of the last five years.

Two of the policy changes adopted by the Board in January 2012 to remediate the losses in the life insurance plan played a major role in offsetting the high claims experienced in 2013. The new reinsurance arrangement returned about $1.75 million to help offset the high death claim payments, while the rate increase continued to generate additional revenue, which was also an important contributor to the improved overall results.

The difficulties experienced by the life plan 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. Although the results for both 2012 and 2013 have been encouraging, 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 financially self-supporting position. While we believe this approach offers a reasonable chance for improving the plan's experience, we will need to continue to monitor developments carefully and be prepared to revise the strategy if the results vary from our expectations.

Office Overhead

The office overhead plan experienced a loss of about $350,000 during 2013. As with the health plan, this was expected since, in recognition of the strong PSF, the office overhead plan benefits were enhanced effective Nov. 1, 2010. The plan's PSF balance is about $7.9 million as of Oct. 31, 2013, and remains extremely strong.

Long-Term Disability

The LTD plan experienced another good year with a gain of $1.7 million. The PSF balance for the LTD plan now exceeds $62.9 million.

Last year was the 16th consecutive year in which the LTD plan has generated a gain. 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 were implemented Feb. 1, 2007, and May 1, 2008.

The most recent rate reductions, which averaged about 20%, have slowed the growth of the PSF and, over time, could 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 2014

Just like last year, 2014 will be another year of great uncertainty for our members due in large part to the continuing implementation of the ACA. Although most provisions of the ACA were scheduled to go into effect Jan. 1, 2014, the bungled implementation of the Federal Health Insurance Exchange (FHIX) has resulted in postponements and deferments of a number of the provisions. 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 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. Beginning 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 help extend health insurance to individuals for whom it is presently unaffordable. Finally, the ACA provides for the creation of a health insurance exchange in every state to 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**. The cost of health insurance is driven primarily by the utilization and cost of health care. 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. While there are initiatives encouraged by the ACA that are intended to "bend the cost curve," 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 already have been implemented during the last four years, 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 the upholding of the ACA requirement that most U.S. citizens and legal residents maintain qualifying health insurance or pay a penalty, commonly referred to as the individual mandate. The annual penalty, which will phase in over three years, is based on a flat dollar amount ($95/adult; $47.50/child in 2014, increasing in two steps to $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, increasing in two steps to 2.5% in 2016). The flat dollar amounts will be indexed for years after 2016. While there continue to be attempts to postpone the implementation of the individual mandate, 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 that does not choose to establish its own exchange. The FHIX is operating in Texas, as the state did not establish its own exchange. Open enrollment for 2014 coverage through the FHIX ran from Oct. 1, 2013, through Mar. 31, 2014. The 2015 open enrollment period will run from Nov. 15, 2014, through Feb. 15, 2015. Although the FHIX got off to a slow and rocky start last fall, it seems to be working at this time.
- **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) will also be available to those with household incomes up to 250% of FPL. The 2014 FPL is $11,670 for an individual and $23,850 for a family of four. The FPL is revised 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 and 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 2014. These requirements, which were originally intended to go into effect in 2014, have been delayed until 2016 for employers with 50-99 employees; the requirements have

been 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 of 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 to the health savings account limits under existing federal law ($6,350 for an individual and $12,700 for a family in 2014). 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.

Even as implementation of the ACA proceeds, a number of initiatives to thwart or change the law continue.

- **Pending Litigation.** Presently, various cases are making their way through the courts. Some of these challenge the constitutionality of the ACA's provisions related to contraception, provider reimbursement, and the Independent Payment Advisory Board. But the most important may be the lawsuit filed by the Oklahoma attorney general arguing that federal subsidies to support the purchase of qualified health insurance through the exchanges are only available when the exchange is created by the state, not the federal government. As many states, including Texas, have not created a state exchange, this challenge, if successful, could have far-reaching effects.
- **Federal Budget.** The partial government shut down last fall was over the U.S. House of Representatives' attempt to postpone implementation. This strategy appears to be off the table for the time being.
- **Legislation.** Congress continues to consider a number of bills that would amend the ACA. While it seems unlikely that significant changes will be passed by both houses and signed by President Obama, such efforts are likely to continue, especially if the Republicans gain control of the Senate in the upcoming mid-term election.
- **Health Insurance Industry Response.** Currently, 12 health insurers are offering health plans in Texas through the FHIX. These carriers are offering a total of 95 plans, although all plans and all carriers are not available in all areas of the state.
- **Cost of Coverage**. The cost of coverage available in Texas through the FHIX varies widely by benefit tier (bronze, silver, gold, or platinum), carrier, age, and area of the state. The cost is currently lower than many expected, although the benefits may also be less generous that those that many insureds have been used to.

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, the changes described above do not apply to the TMAIT health plan. As a result, there were no significant changes on Jan. 1, 2014; 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

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TMAIT health plan will be adversely impacted by new ACA-imposed taxes and fees that will be assessed against all health insurance plans beginning Jan. 1, 2014. Also, the Trust intends to continue its long-standing practice of requiring satisfactory evidence of insurability for applicants seeking new or enhanced coverage.

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. As a result, there are likely to be numerous changes to plans provided through the Agency as we move through 2014 and into 2015.

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 the full impact of these changes on our plan and our insurance partner, BCBSTX, over the long term cannot be predicted. Our membership can be certain, however, that the Trustees and the 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 that are available only to TMA members. This will not change with the ACA. In fact, we are prepared to help members who are shopping both in and out of the FHIX. We know there will be much confusion, and we will be there 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.

We are currently engaged in several initiatives designed to improve services to our members.

- **Private Insurance Exchange (PIX).** The implementation of public federal and state health insurance exchanges under the ACA has encouraged the development of private insurance exchanges (PIXs). 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 are evaluating various software platforms to determine their potential for meeting the needs of our members in the insurance market of the future.
- **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 are studying our current marketing capabilities to determine how they can be updated and improved to meet our organizational goals, both in the near- and long-term.

- **Social Media.** Traditional business practices have been affected dramatically by the advent of social media, both from a cultural as well as a technological perspective. TMAIT is currently engaged in a staff training process to utilize social media effectively in our business activities.
- **Technology.** TMAIT staff are analyzing our technological capabilities and needs in order to enhance marketing effectiveness, member services, and administrative efficiency. This analysis includes:
  - The examination of our current technology, website design, recordkeeping system, and the manner in which we interact with current and future members of the Trust;
  - The assessment of existing technology vendor relationships; and
  - The evaluation of available insurance software platforms to determine those that would best fit our needs.

  The goal of this initiative is to establish a technology plan and operational procedures that will help us maintain our competitive edge in the physician insurance market.

In spite of the many challenges and changes that have occurred in the association insurance market and the medical profession in the last 10 years, the package of products TMAIT provides its membership continues to grow in value. At a time when health insurance has been disappearing from the portfolios of numerous insurance organizations, TMAIT has continued to offer a wide variety of traditional indemnity, PPO, and consumer-directed health care products. Our move to BCBSTX and the creation of the Agency have expanded the range of health insurance products we are able to offer and have improved the viability of 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 2014 and 2015 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 the many changes and ongoing challenges related to many more health insurance rules and regulations and changes in insurance markets generated by the ACA.

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 be monitoring the situation carefully and will be prepared to act in the best interest of the membership.

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 that 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.

"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."

Trustees

TMAIT operates under the authority of an eight-member board. During 2013, the Trustees met in person in February, May, and October in conjunction with TMA conferences and meetings of the House of Delegates. 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 that are 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 and legal 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 is generally 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, Richardson, TX 75082. 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 with 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 Statistics for 2013 Annual Report

2013 Benefit Payments

Plan	Benefit Payments
Health	$18.2 million
Long-Term Disability	$7.2 million
Life	$8.0 million
Office Overhead	$1.4 million

Miscellaneous

Total Contributions	$33.5 million
Combined Premium Stabilization Fund	$84.3 million
Net Program Administrative Cost	11.4% of contributions

2013 Program Highlights

Rate of Return on Invested Assets	3.1%
LTD Payments	1,744
Disabled Physicians Receiving LTD Payments	122
New LTD Claims	20
Death Claims	30
Applications	901
Coverage Quotes	2,207
Billings	37,320

2013 Enrollment by Plan

Plan	Enrollment
Life Insurance	4,389
Long-Term Disability	4,102
Office Overhead	1,044
Personal Accident	1,837
Health	2,767
Dental	861

TMAIT Board of Trustees

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