TEXAS MEDICAL ASSOCIATION INSURANCE TRUST

2012 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

As interesting and eventful as my first year as chair of the Texas Medical Association Insurance Trust (TMAIT or the Trust) has been, I think there is much more excitement in store for the next few years, as we approach the "end of the beginning" of a new era of health care reform. I don't think I will need to spend any time worrying whether, to paraphrase the old proverb, I will serve "in interesting times."

In our 2012 Annual Report, we will recap the last year and look into the future as we approach full implementation of the Patient Protection and Affordable Care Act on Jan. 1, 2014.

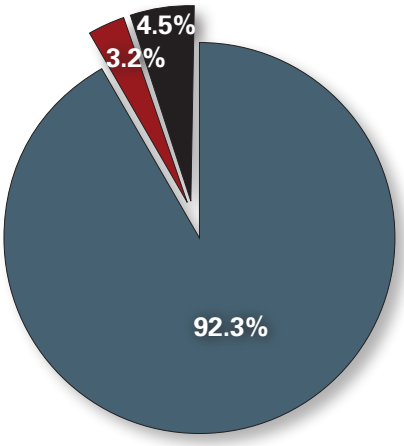
Once again, I will begin with a brief overview of the Trust's financial history before discussing the significant developments and financial results of the past year.

- Since 1969, our members have contributed about **$1.57 billion** to the Trust.
- Over the last 43 years, the Trust has paid benefits or set aside as reserves for future benefit payments a total of **$1.45 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 (net of investment income) of **about $50 million** since 1969. Net administrative expenses represent **3.2%** 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 **$85 million** PSF has been developed from the following sources:
  - About **$71 million** in member contributions (**4.5%** 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.

Uses of the member contributions to TMAIT over its 43-year history are shown in Exhibit 1.

Exhibit 1

Uses of Member Contributions to TMAIT, 1969-2011



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 program 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 12 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 4.5% of contributions over the 43-year history of the Program.

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.

"The Trust has enjoyed gains in many more years than it has experienced losses, with 31 years of gains and only 12 years of losses."

Exhibit 2

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

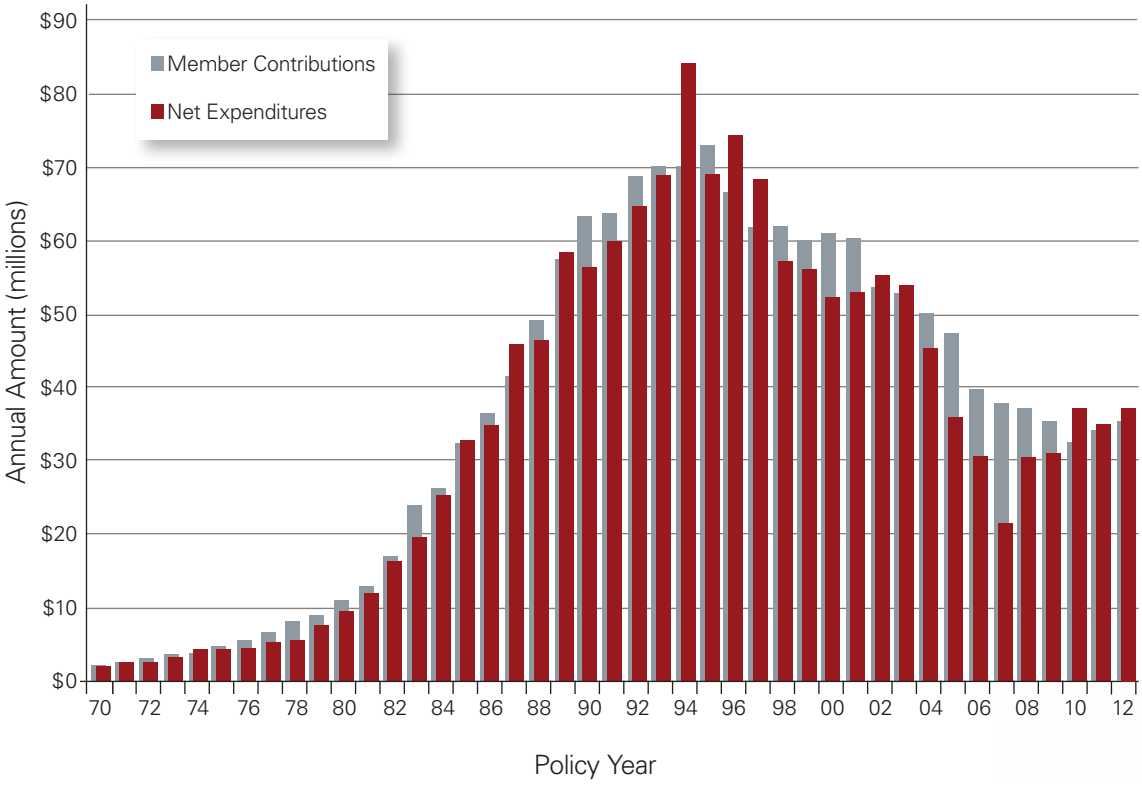


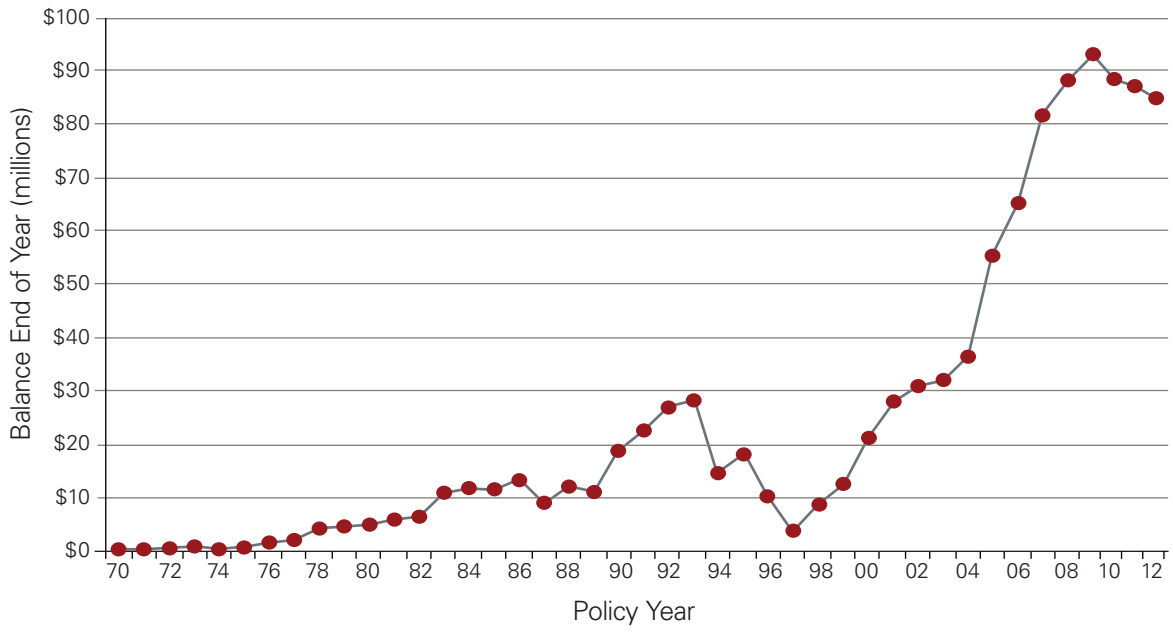
Exhibit 3 presents the historical growth of the fund.

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 three 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 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. Prior to 2010, we had not increased health rates since Nov. 1, 2006. Even though it is unusual for rates to remain adequate for more than one year due to continuously rising health care costs, the rates adopted in 2006 remained adequate through 2008. During 2009, the experience worsened, and the health plan generated a loss of about $2 million. Nevertheless, due to the strength of the PSF, the Trustees decided to maintain the rates through most of 2010. While this decision cost the PSF $4 million during 2010, we believed that it was an appropriate means of returning funds to our members at a time when such assistance would surely be welcome.

Exhibit 3

TMAIT Premium Stabilization Fund Balance for All Plans Combined



Continuing increases in the claims incurred under the health plan gradually eroded the adequacy of the contributions, and it was finally necessary to increase the rates by an average of about 15% effective Nov. 1, 2010. The Trustees chose to increase the rates by only 15% even though projections indicated that a 25% increase would be required for the health plan to break even during 2011. The Trustees made this decision to continue to use the PSF to subsidize the rates due to the size of the PSF and a desire to mitigate the impact of the rate increase on the membership. This strategy cost the PSF about $1.4 million during 2011.

The Trustees followed a similar strategy in deferring the next health plan rate increase until Aug 1, 2012. At that time, the Trustees increased the rates by an average of 14% even though the projection model indicated that a 17.5% increase would be required for the plan to break even over the next year. The deferral and the continued rate supplementation cost the plan about $2.4 million in 2012.

- **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 three years have reduced the PSF to about $85 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 2012 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. At the end of 2012, the Agency was providing coverage for about 7,700 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 three rate increases since we joined forces nearly 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 43 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 be working especially hard during 2013 as we prepare to assist our members with the many issues arising from full implementation of the Patient Protection and Affordable Care Act (PPACA) on Jan. 1, 2014.

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 2012 policy year, the insurers used 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 1,579 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 3.2% 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 2012 were about 10.7% of member contributions, slightly higher than the 9.2% rate experienced in 2011. 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.

2012 Financial Results

Overall, the Program experienced an operating loss of about $2.1 million during 2012. This was the third consecutive year that the Program has experienced negative operating results. 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 2012 policy year, the Program maintained required claim reserves of about $45 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 2012 policy year, the Program's PSF balance was about $85 million, equivalent to almost 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 and health insurance, 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 the members during each of the last four years. Overall, the health plan produced a cumulative loss of almost $10 million over that period.

As mentioned earlier, the PSF balance that accumulated in good times has allowed us to cover the health plan funding deficiencies, thus permitting us to defer rate increases as long as possible. Nevertheless, to maintain a financially secure health plan, it was finally necessary to increase rates by an average of 15% effective Nov. 1, 2010. This rate increase, the first since 2006, represented an annual average rate of increase of only about 3.5% from 2006 to 2010. The increase, when supplemented with about $2 million from the PSF, was intended to provide sufficient revenue to support the health plan during 2011. As experience was slightly better than expected, we required a supplement of only $1.4 million during 2011. As a result, we were able to maintain rates for 21 months until Aug. 1, 2012, when we again implemented an increase that was supplemented by the PSF. The rate supplements over the last four years reduced the PSF to about $14.3 million as of Oct. 31, 2012.

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 2013.

"... We are pleased to report that the life insurance plan came very close to breaking even for 2012."

Life Insurance

In the 2011 Annual Report, we reported that the life insurance plan had 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 included 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 last summer in an attempt to attract new, healthy participants.

While it is much too early to declare success, we are pleased to report that the life insurance plan came very close to breaking even for 2012. There were significantly fewer death claims in 2012 (23) as compared with 2011 (32), and the total payments ($3.2 million) were less than 50% of the level in 2011 ($7.1 million). As the plan set a new record for annual death claim payments in 2009, again in 2010, and yet again in 2011, the 2012 experience was a welcome change. For the last several years, the plan's experience was adversely impacted by large claims late in the year. Fortunately, that pattern did not repeat itself during 2012. There were four claims of $400,000 or more during 2012 as compared with eight in 2011. There were two claims of $1.0 million or more in 2011, but there was only one of that magnitude in 2012. The plan's PSF balance stands at about $1.3 million as of Oct. 31, 2012.

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 2012 results were encouraging, one year does not provide a sufficient basis 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 monitor developments carefully and be prepared to revise the strategy if the results vary from our expectations.

Office Overhead

The office overhead plan also experienced near breakeven results during 2012. The plan's PSF balance is about $8.2 million as of Oct. 31, 2012, and remains extremely strong. In recognition of the strong PSF, the office overhead plan benefits were enhanced effective Nov. 1, 2010.

Long-Term Disability

The LTD plan experienced another good year with a gain of $600,000. The PSF balance for the LTD plan now exceeds $61.2 million.

Last year was the 15th 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 begun to slow 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 2013

The TMAIT Trustees and staff recognize that 2013 is a year of great uncertainty for our members due in large part to the impending implementation of the Patient Protection and Affordable Care Act (PPACA or the Act) on Jan. 1, 2014. Although it has been three years since the U.S. Congress adopted the Act, extensive regulations have been issued, experts and non-experts alike have contemplated and opined about the impact of the law, and a landmark Supreme Court decision has been rendered, there is still much that is not fully understood. As a result, there is a great deal of misinformation about the Act. Therefore, the remainder of the TMAIT Annual Report is devoted to a discussion of the Act and its implications.

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

- The PPACA is first and foremost about **access to health insurance.** By prohibiting evidence of insurability requirements and preexisting condition limitations, the PPACA 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) and providing various forms of premium and cost-sharing subsidies, the PPACA will help extend health insurance to individuals for whom it is presently unaffordable. Finally, the Act 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 PPACA 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 PPACA includes much regulation, but it will not regulate the cost of health care. The Act 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%. While there are initiatives encouraged by the Act 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, the cost of health insurance.

"The TMAIT Trustees and staff recognize that 2013 is a year of great uncertainty ..."

While various PPACA provisions already have been implemented during the last three years, the Act's most sweeping changes are scheduled for 2014. Those with the most significance to physicians and their employees include the following.

- **The Individual Mandate.** The primary focus of the Supreme Court's landmark decision in June 2012 is the PPACA 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, will be 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.
- **Health Insurance Exchanges.** The PPACA provides for the creation of state-based health insurance exchanges (HIXs) to be administered by a government agency or nonprofit organization. The state-based HIX will serve as a market clearinghouse for qualifying health insurance coverage for individuals and small businesses with 100 or fewer employees. The Act authorizes each state to create its own HIX; however, the Act authorizes the U.S. Department of Health and Human Services (HHS) to establish a federally facilitated exchange (FFE) in a state that does not choose to establish its own HIX. At this writing, Texas has not taken steps to establish a HIX, so it appears that an FFE will operate in the state, at least in 2014. Open enrollment for coverage through the exchanges for 2014 will begin Oct. 1, 2013.
- **Health Insurance Premium and Cost-Sharing Subsidies.** Sliding-scale premium subsidies will be available to individuals and families with household income of 100-400% of the Federal Poverty Line (FPL) to purchase individual insurance through the HIX. Sliding-scale cost-sharing subsidies (assistance in paying deductibles, coinsurance, and copayments) will be available to those with household incomes up to 250% of FPL. The 2013 FPL is $11,490 for an individual and $23,550 for a family of four. The FPL is revised annually, usually in late January.
- **Guaranteed Availability of Health Insurance.** The PPACA requires guaranteed issue and renewability of health insurance purchased through the HIX 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 HIX will be subject to an annual penalty of $2,000 for each FTE in excess of 30. Employers *with 50 or more employees* who 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. *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 HIX.*

- **Essential Health Benefits.** The PPACA 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 ($6,250 for an individual and $12,500 for a family in 2013). 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 HIX.

While the Act is clear about *what* happens in 2014, there is little clarity about how it will happen. Among the unknowns at this point are the following.

- **Health Insurance Exchange in Texas.** It seems likely at this time that the Texas HIX will be an FFE as discussed previously. Only the broadest guidelines for operation of the FFE have been issued to date. As a result, little is known about how the FFE would operate or the impact that it would have on the health insurance market in Texas. Of course, it's always possible that the Texas legislative leadership could change course and create a HIX, though that seems highly unlikely for 2014.
- **Pending Litigation.** Presently, various cases are making their way through the courts. Some of these challenge the constitutionality of the Act'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 HIXs are only available when the HIX is created by the state, not the federal government. As many states, including Texas, do not plan to create a HIX, this challenge, if successful, could have far-reaching effects.
- **Federal Budget.** The ongoing federal budget debate could influence the speed and extent to which the Act is implemented, as budgetary limitations could affect HHS action.
- **Legislation.** The new Congress will likely consider a number of bills that would amend the PPACA. While it seems unlikely that significant changes will be passed by both houses and signed by President Obama, it is certainly possible that some changes could occur in time to impact 2014.
- **Health Insurance Industry Response.** Texas health insurers continue to consider their options in light of the changes and uncertainty in the market as Jan. 1, 2014, approaches. There is no requirement that an insurer participate in the HIX, although many of the requirements of the PPACA apply outside as well as inside the exchange. None of the companies has announced specific plans at this point; of course, that would be hard to do in light of the ongoing uncertainty.
- **Cost of Coverage.** While there has been much speculation about the cost of health insurance once the PPACA is fully implemented, there is no specific information available at this time. Generally speaking, the adverse selection that can be expected to accompany guaranteed issue will lead to cost increases, particularly for individual insurance, as people with health problems are more likely than healthy people to purchase health insurance. In addition, the more extensive coverage required under the Act as well as new fees to be assessed against insurance companies are also expected to increase cost. Nevertheless, it is unlikely we will know anything specific about cost until late 2013.

"TMAIT health plan members will continue to receive the same coverage they have been receiving in the past."

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

First, the PPACA 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 Act impacts health insurance plans, the TMAIT health plan is a "grandfathered health plan" under the PPACA. While we have already 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. This means there will be no significant changes on Jan. 1, 2014; i.e., TMAIT health plan members will continue to receive the same coverage they have been receiving 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 PPACA has not changed anything that drives the factors that influence the cost of health insurance. Unfortunately, the TMAIT health plan will be adversely impacted by new 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 PPACA including those described previously. As a result, there are likely to be numerous changes to plans provided through the Agency as we head into 2014.

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 implementation of the PPACA. In fact, we are prepared to help members who are shopping both in and out of the HIX. 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 have recently introduced several initiatives designed to improve our services and educate our members.

- TMAIT has created special landing pages on the TMAIT website that are unique to each resident facility enrolled in TMAIT insurance plans. These pages provide information about the plans in which residents may enroll, the availability of continued coverage upon completion of residency, TMA membership, and online enrollment.
- The Texas Medical Group Managers Association in partnership with TMAIT recently completed a salary survey for medical practice employees in Texas. Our goal in administering this survey is to provide practice administrators with meaningful information for budgeting and staff management.
- In May, TMAIT will launch an informative video series in which several TMAIT staff members will discuss the types of programs available to TMA members through TMAIT. The series will include product discussions and acquaint TMA members with the process involved when requesting a quote or applying for coverage.

In spite of the many challenges and changes that have occurred in the association insurance market and the medical profession during 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 2013 and 2014 to present many of the same challenges that we have been dealing with in recent years: a fragile economy, changes in the delivery of health care, strained federal and state budgets, and ongoing debate and litigation on health care reform. But the next several years will also present a new set of challenges as we enter the new world of the PPACA, with many more health insurance rules and regulations and changes in insurance markets.

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 Trust remains the best source for reliable assistance in the health insurance marketplace."

Trustees

TMAIT operates under the authority of an eight-member board. During 2012, the Trustees met in person in January, 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 August.

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 22-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 immediate 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.

2012 Benefit Payments

Plan	Benefit Payments
Health	$19.4 million
Long-Term Disability	$8 million
Life	$3.2 million
Office Overhead	$0.9 million

Miscellaneous

Total Contributions	$34.7 million
Combined Premium Stabilization Fund	$85.1 million
Net Program Administrative Cost	10.7% of contributions

2012 Program Highlights

Rate of Return on Invested Assets	3.1%
LTD Payments	1,798
Disabled Physicians Receiving LTD Payments	115
New LTD Claims	14
Death Claims	23
Applications	882
Coverage Quotes	1,700
Billings	32,556

2012 Enrollment by Plan

Plan	Enrollment
Life Insurance	4,479
Long-Term Disability	4,138
Office Overhead	1,057
Personal Accident	1,857
Health	3,276
Dental	869

TMAIT Board of Trustees

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